CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

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INTRODUCTION

The Commonwealth of Virginia offers the following waivers under the Medical Assistance Program:

Day Support Waiver (effective July 1, 2005);
Alzheimer's Disease Waiver (effective September 1, 2005);
Elderly or Disabled with Consumer Direction Waiver;
HIV/AIDS Waiver;
Technology Assisted Waiver;
Mental Retardation Waiver; and
Individual and Family Developmental Disabilities Support Waiver.

These waivers differ according to the populations they target, the medical and functional criteria for eligibility for each waiver, the pre-admission screening (PAS) process for each waiver, and the services offered under each waiver. Under no circumstances can a recipient be enrolled in and receive services under more than one waiver during the same time period. Recipients may be on a waiver and on a waiting list for another waiver at the same time if they meet criteria for both waivers.

ELDERLY OR DISABLED WITH CONSUMER DIRECTION (EDCD) WAIVER

The Department of Medical Assistance Services (DMAS) provides payment for the services provided in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, which is designed to offer recipients an alternative to nursing facility placement. These services include personal care (agency- and consumer-directed), skilled respite (agency-directed), non-skilled respite (agency- and consumer-directed), Adult Day Health Care (ADHC) and Personal Emergency Response Systems (PERS).

The PAS Team must deem the recipient eligible for EDCD Waiver services. DMAS or its pre-authorization contractor must preauthorize all waiver services in order for the provider to be reimbursed. DMAS contracts with the pre-authorization contractor to conduct pre-authorization for EDCD Waiver services. Recipients may be authorized to receive one or more of these services, either solely or in combination, based on the documented need for the service(s) and the recipient's choice of services, with the exception that PERS is not a stand-alone service and requires personal care, respite, or ADHC as the primary service.

EDCD services may not be authorized for individuals who reside in a nursing facility, an intermediate facility for the mentally retarded, a hospital, an assisted living facility licensed by the Department of Social Services (DSS), or an adult foster care provider certified by DSS.

SCREENING PROCEDURES FOR EDCD WAIVER SERVICES

EDCD Waiver services will be offered as an alternative to a nursing facility only to recipients who have been determined eligible for EDCD Waiver services by a PAS Team and authorized by the pre-authorization contractor, and for whom an appropriate and cost-effective Plan of Care can be developed. The PAS Team must have explored the medical, social, and nursing needs of the recipient, analyzed the specific service needs of the recipient, and evaluated whether a service or combination of existing services is available to meet these needs. The PAS Team must have explored alternative settings and services to provide the required care before making the referral for the EDCD Waiver services. (See the "Exhibits" section at the end of this chapter for a copy of the nursing facility criteria.)

Federal regulations governing Medicaid coverage of home- and community-based services under an approved waiver specify that services provided under waiver authority must only be provided to recipients who have a need for the level of care provided in an alternative institutional placement when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home- or community-based services. Under the EDCD Waiver, services may be furnished only to recipients:

1. Who meet the nursing facility criteria as outlined in the "Exhibits;"
2. Who are eligible for Medicaid;
3. For whom an appropriate, cost-effective Plan of Care can be established;
4. Who are not residents of nursing facilities (licensed by the Virginia Department of Health), assisted living facilities (licensed by DSS), or adult foster homes (approved by local DSS);
5. When there are no other or insufficient community resources to meet the recipients' needs; and
6. Whose health, safety, and welfare (HSW) in the home environment can be ensured.

EDCD Waiver services must be the critical services that enable the recipient to remain at home rather than being placed in a nursing facility.

A request for a pre-admission screening for nursing facility placement can be initiated by the recipient who desires the requested care, a family member, a physician, hospital staff, the local health department, a social services professional, or any other concerned individual in the community. The appropriate assessment instrument, the Uniform Assessment Instrument (UAI), must be completed in its entirety.

The Pre-Admission Screening packet consists of the following forms:

- A complete Virginia Uniform Assessment Instrument (UAI - 12 pages);
- The Screening Team Authorization (DMAS-96);
- The Screening Team Plan of Care (DMAS-97);
- The DMAS-101A&B (for recipients who have a diagnosis of Mental Illness, Mental Retardation, or a Developmental Disability that meets the definition of a Related Condition in 42 CFR §435.1009);
- Documentation of the recipient's choice;
- The PAS Team decision letter;
- The DMAS-95A Consumer Direction Addendum (questionnaire to assess an applicant's ability to independently manage personal assistant services in the EDCD Waiver), if applicable; and
- The DMAS-95B Consumer Direction Services Management Questionnaire (questions to consider if you want to manage Consumer Direction Services on behalf of a family member).

See the "Exhibits" section at the end of the chapter for samples of the forms listed above. All of these forms must be submitted to the provider chosen by the recipient to provide services.

The screening packet must be signed and complete, and the assessment and authorization (DMAS-96) must be approved by the Public Health physician (for recipients in the community) or attending physician (for recipients in the hospital). The Screening Team Plan of Care (DMAS-97) indicates the services needed, any special needs of the individual and environment, and the support available to provide services.

If authorizing ADHC, the PAS Team must indicate on the DMAS-97 the number of days the recipient will be attending and whether transportation services will be required. The pre-authorization contractor review analysts use this information to enter the amount of services into the recipient's file. This is the amount of service for which the provider is authorized to bill DMAS. Increase of days in ADHC attendance must be pre-authorized by the pre-authorization contractor.

If authorizing personal/respite care, the PAS Team must indicate on the DMAS-97 the services needed, any special needs of the recipient's environment, and the support available to provide services. The PAS Team will note the number of days per week that care is needed but will not authorize the amount of service each day. Supervision time may be authorized on the DMAS-97 by the PAS Team. This allows the provider to include supervision in the Plan of Care, within the level-of-care hours. If supervision will exceed the level-of-care hours, this must be pre-authorized by the pre-authorization contractor. The Screening Team Plan of Care also serves as

written notification to the recipient of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the recipient's choice of long-term care options and choice of provider.

If EDCD Waiver services are authorized, the PAS Team must provide the individual with a list of providers. The recipient must have the option of selecting the provider of his or her choice from among those that are willing and able to provide care.

The decision of the PAS Team may be appealed to DMAS in writing by the recipient or his or her legally appointed representative. All appeals must be filed within 30 days of the date of the final decision notification. Appeals are to be directed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

AUTHORIZATION FOR MEDICAID PAYMENT OF EDCD SERVICES

Screening by the PAS Team and pre-authorization of EDCD Waiver services by the pre-authorization contractor is mandatory before Medicaid will pay for EDCD Waiver services.

Medicaid will not pay for any EDCD Waiver services delivered prior to the authorization date of the physician's signature on the DMAS-96. The date of this authorization cannot be made prior to the date on which the assessment is completed and the PAS Team makes a decision.

Medicaid will pay for EDCD Waiver services only after the DSS has determined that the recipient is eligible for medical assistance for the dates services are to be provided.

The personal care agency, ADHC, or Service Facilitator, with the most authorized hours must request an updated DMAS-122 form from the local DSS annually and forward a copy of the updated DMAS-122 form to all service providers when obtained. All providers must notify each other, as well as the pre-authorization contractor, of any change, including discontinuation of services, that occurs in the recipient's Plan of Care or provision of services via the DMAS-122. A respite provider is responsible for the DMAS-122 only if respite is the sole service provided.

DETERMINATION OF MEDICAID ELIGIBILITY

Every recipient who applies for Medicaid-funded long-term care must have his or her Medicaid eligibility evaluated, or re-evaluated, if already Medicaid eligible, by the DSS in the city or county in which he or she resides. This evaluation is completed at the same time the PAS Team completes its evaluation of whether a recipient meets waiver criteria.

For questions about eligibility criteria or a recipient's eligibility status, contact the local DSS eligibility worker.

MEDICAID APPLICATION PENDING

DMAS cannot pay for EDCD Waiver services unless:

Screening by the PAS Team and pre-authorization of EDCD Waiver services by the the pre-authorization contractor is mandatory before Medicaid will pay for EDCD Waiver services;

The recipient is Medicaid-eligible on the dates that services are rendered; and

The recipient has received services that are covered under the EDCD Waiver as defined by DMAS.

There may be cases in which the recipient has been assessed and approved for services through the PAS process, but Medicaid eligibility has not been determined/re-determined. In these cases, the provider may choose to provide services, as approved by the PAS Team, while awaiting the eligibility decision by the local DSS regarding Medicaid financial eligibility, but does so without a guarantee of payment from DMAS. The provider cannot bill for services provided until the provider verifies that Medicaid has been approved for waiver services via a DMAS-122 from the local DSS.

If the recipient is determined to be Medicaid-eligible, the date of Medicaid eligibility may be retroactive (i.e., the effective eligibility date established is prior to the date of approval of the Medicaid application). DMAS may pay the provider to the retroactive date of eligibility if the provider submitted the request for authorization to the pre-authorization contractor within 10 business days of receiving verification of eligibility on the DMAS-122.

PATIENT INFORMATION FORM (DMAS-122)

The Patient Information Form (DMAS-122) is used by the DSS to inform providers of Medicaid eligibility. It is also used by providers, the CD Fiscal Agent, and the local DSS to exchange information regarding the responsibility of a Medicaid-eligible recipient to make payment toward the cost of services or other information that may affect the eligibility status of a recipient.

Immediately upon initiation of services, the provider/facilitator must send a DMAS-122 to the eligibility unit of the appropriate local DSS indicating the provider's first date of service delivery.

After being notified of the begin date of service, the eligibility worker will return the Service Facilitator's DMAS-122 to the provider with the bottom section completed, confirming the date on which the recipient's Medicaid eligibility was effective, the Medicaid identification number, and the recipient's patient pay amount, if applicable. A copy of this completed DMAS-122 must be maintained by the provider in the recipient's file.

The provider must ensure that a completed DMAS-122 for the current service year is in the recipient's record prior to billing. A new DMAS-122 is generated by the local DSS at least annually, or when the recipient's patient pay changes.

When multiple providers are involved in the recipient's care, the providers must coordinate the DMAS-122 process. If the provider responsible for the patient pay does not render services for the month equal to or above the patient pay amount, that provider must contact the provider with the next most authorized hours. The next provider will be responsible for collecting the balance of the patient pay amount. The provider with the most authorized hours must send all other providers a copy of the most recent DMAS-122.

When consumer-directed (CD) services are in place, the pre-authorization contractor must be notified of who will be collecting the patient pay amount.

The provider/CD Service Facilitator (CDSF) must notify the pre-authorization contractor via the DMAS-98 and the local DSS via the DMAS-122 of the provider's/CD Service Facilitator's last date-of-service delivery when any of the following circumstances occurs:

- A recipient no longer meets criteria for the services;
- A recipient dies - include the date of death;
- A recipient is discharged or discontinued from services - The date of discharge or discontinuation should be the last date services were rendered for that recipient. This includes when the recipient is discharged from one provider agency and admitted to another; and
- Any other circumstances (including hospitalization) that cause services to cease or become interrupted for more than thirty (30) days.

  EXAMPLE: The provider delivered services to a recipient through the third of the month, and then the recipient was hospitalized and died on the fifteenth of the month. Even though the provider/CD Service Facilitator kept the case open to see if the recipient would need services post-hospitalization, the date submitted on the DMAS-122 would be the third since this was the last day the recipient received waiver services.

<u>Patient Pay Amount</u>

Each waiver recipient is allowed to keep a portion of his or her income to meet maintenance needs. This is called a personal maintenance allowance (PMA). The PMA is higher for an individual staying at home receiving community-based care than for an individual in a nursing facility. The PMA for recipients of the EDCD Waiver is usually equal to 100% of the current Supplemental Security Income (SSI) individual payment standard.

The PMA and other allowable deductions (e.g., medical insurance payments) are deducted from the individual's income to arrive at that individual's patient pay amount. The patient pay from a SSI recipient will always be $0.

Working individuals have a greater need due to expenses of employment; therefore, an additional amount of earned income shall be deducted. Earned income shall be deducted as follows: (i) for individuals employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% of the SSI payment standard, and (ii) for individuals employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of the SSI payment standard.

The provider with the most authorized hours is considered the primary service provider and is responsible for the collection of any patient pay amounts indicated by DSS on the DMAS-122. (The "Exhibits" section at the end of this chapter contains a sample of the form and the instructions for its completion.) If an individual is receiving multiple waiver services, the provider agencies are responsible for determining which is the most authorized waiver service and, therefore, which provider is the primary provider that will handle patient pay collection. The primary provider must contact the eligibility worker at DSS to instruct him/her where to send future DMAS-122s. The primary provider is responsible for sending current and future copies of the DMAS-122 to the other waiver service providers.

If a provider agency does not know if the recipient is receiving other waiver services, the provider will first contact the recipient or family member/caregiver to obtain information regarding other waiver services being rendered. If the provider is unable to obtain accurate information from the recipient or family member/caregiver, the provider should contact the CBC unit at the pre-authorization contractor. The pre-authorization contractor will only give the following information regarding multiple services for a recipient:

1. The waiver services that the recipient is receiving;
2. The name(s) of the other service provider(s); and
3. The phone number of the other service provider(s).

The pre-authorization contractor will not give the amount of authorized hours for the service(s), or what provider is the primary provider, or any other contact information than what is listed above.

Patient Pay Collection for Consumer Direction (CD) as the Primary Service

If CD service is the most authorized service the recipient is receiving, the CD Service Facilitator (CDSF) is responsible for sending a copy of the DMAS-122 with the patient pay amount to the CD Fiscal Payroll Agent. The SF must send the DMAS-122 to the Fiscal Agent as soon as possible so that the patient pay amount can be deducted from the CD personal care aide's payroll. It is also necessary for the CDSF to include the patient pay amount in the admission

packet for CD services to the preauthorization contractor. If the patient pay amount changes in the future, both the pre-authorization contractor and the CD Fiscal Payroll Agent must receive a copy of the DMAS-122 with the new patient pay amount.

ADHC Patient Pay Calculation

An authorization for ADHC is per day, as opposed to per hour like personal and respite care. If a recipient is authorized for additional waiver services other than ADHC, the ADHC per-day authorization must be calculated into an hourly rate when determining which service provider is to be responsible for the patient pay. The authorization of one day of ADHC by the pre-authorization contractor is considered equivalent to six hours of authorized service hours. For example, if a recipient is authorized for 23 days for the month, the ADHC equates this as 138 authorized hours per month.

Respite Care as the Sole Service

Respite care providers are <u>only</u> responsible for collecting the patient pay when respite care is the sole service authorized.

Below, you will find examples that determine who is responsible for collecting the patient pay when an individual is authorized for multiple waiver services:

EXAMPLE 1:
John Doe is authorized for 55 hours of agency-directed personal care services per month (12 hours per week) and ADHC services for 12 days per month (1 day = 6 hours). The ADHC is authorized for 72 hours per month, whereas the personal care agency is authorized for 55 hours per month. The ADHC is responsible for collecting the patient pay from John Doe.

EXAMPLE 2:
John Doe is authorized for 46 hours per month of agency-directed personal care services, 92 hours per month of CD personal care services, and four days per month of ADHC (4 days x 6 hrs = 24 per month). The recipient is authorized for more CD services than he is for the other services. Therefore, the patient pay will be collected through the CD services.

EXAMPLE 3:
John Doe has been authorized for 46 hours per month of agency-directed personal care for the last year and has recently been authorized for 64 hours per month of CD personal care. The agency-directed provider will send the original DMAS-122 to John's CD Service Facilitator (SF) because John is now authorized for more CD services per month than agency-directed services. The CDSF will send a copy of the DMAS-122 to the CD Fiscal Payroll Agent.

If the amount of services rendered by the primary provider is less than the recipient's patient pay for a given month, the primary provider must contact the provider with the next most authorized service hours with the balance of the patient pay amount that has not been collected from the recipient. This secondary provider will be responsible for collecting the patient pay balance.

If the amount of services rendered by the primary provider is equal to the recipient's patient pay for a given month, the provider will not bill DMAS for services rendered.

LAPSE IN SERVICE OF 30 DAYS OR MORE

The provider must send a DMAS-122 to the local DSS eligibility worker when any recipient who, for any reason including hospitalization, does not receive services for 30 days or more. If a recipient has a lapse in services for at least 180 days, but less than 365 days, even if the recipient returns to the same provider, the screening must be updated by the local PAS Team.

If the Registered Nurse (RN) Supervisor, CD Service Facilitator, or ADHC Coordinator/Director believes that the recipient may no longer meet the level-of-care criteria, that person is to notify the pre-authorization contractor using the DMAS-98.

AGENCY-DIRECTED (AD) AND CONSUMER-DIRECTED (CD) MODELS OF SERVICE

Individuals may receive Personal Care, Adult Day Health Care (ADHC), Respite, Skilled Respite, and Personal Emergency Response System (PERS) through an agency-directed model of care. Individuals may also receive Personal Care and Non-skilled Respite through a consumer-directed model of care. The model of care is chosen by the individual or the caregiver, if the individual is not able to make a choice. This choice must be made freely without interference from the provider or CD Service Facilitator.

Medicaid payment is available only for services provided when the recipient is present, according to an approved Plan of Care, when the services are authorized, and when a qualified provider is providing the services to the recipient. DMAS will not pay for services rendered to or for the convenience of other members of the household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, doing the family's laundry, etc.).

An individual may receive CD services along with AD services. For example, an individual receiving CD personal care services can also receive PERS. However, individuals cannot simultaneously (same billable hours) receive multiple services.

For both AD and CD care, the recipient must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the individual, etc.) in case the personal care aide is unable to work as expected or terminates employment without prior notice. This is the responsibility of the recipient and family and must be identified in the Plan of Care. Recipients who do not have viable back-up plans are not eligible for services until viable back-up plans have been developed.

For AD care, the provider must make a reasonable attempt to send a substitute aide but, if this is not possible, the recipient must have someone available to perform the services needed.

Response To Referral: All Services

The provider or CD Service Facilitator (CDSF) shall not begin services for which they expect Medicaid payment until the admission packet is received from the PAS Team and not before the date authorized by the PAS Team on the DMAS-96. The provider must ensure the receipt of a complete and correct screening packet prior to starting care.

Recipients who are already receiving an EDCD Waiver service and wish to receive an additional service must have this additional service authorized through the pre-authorization contractor. The provider with the responsibility shall not begin services prior to the date on the pre-authorization contractor letter authorizing the additional service. The initial provider must send a copy of the original screening packet, a copy of the pre-authorization contractor authorization letter to add additional services, and a copy of the DMAS-122 to the new provider.

The personal care provider/CDSF must determine, prior to accepting the referral from the PAS Team, whether the provider/CDSF adequately provide services to the recipient. No referral shall be accepted unless the provider has the staff to provide services, and the recipient being referred appears appropriate for the provider's services. There, however, may be instances where the provider/CDSF is unaware of a problem that will prohibit service delivery until the RN Supervisor/CDSF completes the initial assessment.

Individuals choosing to receive personal care services through an agency may do so by choosing a personal care agency to provide their services. Once an agency has accepted the referral, the RN Supervisor must make an initial assessment visit on or before the start of care. An assessment visit must also be made when a recipient is re-admitted after discharge from services or if he/she is transferred from another provider.

Recipients choosing to receive services through the CD model may do so by choosing a CDSF to provide the training and guidance needed to become an employer. As the employer of services, the recipient is responsible for hiring, training, supervising, and firing aides. If the recipient is unable to independently manage his/her own CD services, or if the recipient is under 18 years of age, a spouse, guardian, adult child, or parent of a minor child must serve as the employer on behalf of the recipient. A person serving as a surrogate decision maker cannot be a paid caregiver or CDSF. The caregiver who is managing the care for the recipient cannot be the paid personal care aide.

All CD services require the services of a Fiscal Agent and a CDSF (DMAS-enrolled provider) and must be pre-authorized by the pre-authorization contractor. The CDSF must complete an assessment, a Plan of Care, and continuous documentation of services provided as outlined later in this chapter.

Specific duties of the recipient (or recipient's family member/caregiver serving on behalf of the recipient) as the employer to the CD personal care aide include checking references, determining that the employee meets basic qualifications, training, supervising performance, and submitting time sheets to the Fiscal Agent on a consistent and timely basis. CD aides are not eligible for

Worker's Compensation. Please see the Employee Management Manual for a detailed description of CDSF duties.

Upon receipt of a referral and on or before the delivery of services, the CDSF must make an evaluation visit to the recipient's home.

Service Initiation

Agency-Directed Model

During this initial home visit, the RN Supervisor is responsible for performing and documenting the following activities:

- Introduction of the aide to be assigned to the recipient - Each regularly assigned aide must be introduced to the assigned recipient by the RN Supervisor, or other staff (this may be done by telephone) and oriented to the recipient's Plan of Care on or prior to the aide's start of care for that recipient. The RN Supervisor must closely monitor every situation when a new aide is assigned to a recipient so that any difficulties or questions are dealt with promptly;

- Discussion of the recipient's needs and review the Plan of Care from the PAS Team;

- Completion of the Provider Plan of Care (DMAS-97A/B) and review of this Plan of Care with the recipient or the recipient's family and the aide, to ensure that there is complete understanding of the services that will be provided. The DMAS-97A/B (see "Exhibits" at the end of this chapter for a sample of this form) must be completed with the recipient's name, 12-digit Medicaid number, provider name and identification number, ADL composite score, RN signature, and start-of-care date. (This is the date that the personal care aide actually began providing care, and this date should also be the one used on the DMAS-122.) A copy of the current provider Plan of Care must be kept in the recipient's home. The aide should be instructed to use the provider Plan of Care (either the recipient's copy designating time increments or a copy that shows only the tasks checked) as a guide for daily service provision.

  It is appropriate for the aide to chart tasks that are not included in the recipient's Plan of Care if the recipient has a need for the task to be done. The aide should note why this task was performed. If the need for this task continues to exist, it is then the responsibility of the RN, who reviews the aide records, to determine whether there is a need for the task to be included on the Plan of Care on an ongoing basis and make the appropriate changes; and

1. The RN shall return for a follow-up visit no later than 30 calendar days after the initial visit to assess the recipient's needs and to make a final determination as to whether the recipient's condition meets the definition of severe cognitive impairment. The RN must document this assessment in the recipient's record. Recipients that have severe cognitive impairments, as defined in this chapter, will continue to have supervisory visits every 30 calendar days.

If the recipient does not have a severe cognitive impairment, the RN will work with the recipient to determine the appropriate frequency of supervisory visits. The determination must be based on the recipient's health and safety needs, and not on the convenience of the provider agency. During the RN's assessment visit, the RN must discuss the appropriate frequency with the recipient/caregiver and document the recipient's choice and the reason for the decision in the recipient's record. The RN makes this decision based on professional judgment and has the final authority in this matter.

The RN Supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of personal, respite, and, if applicable, the personal emergency response and medication monitoring systems services. A minimum frequency of these visits is every 30 calendar days for recipients with a severe cognitive impairment and up to, but not to exceed, every 90 calendar days for recipients who do not have a severe cognitive impairment as defined in this chapter. Supervisory visits solely for social purposes are not covered services.

Based on continuing evaluations of the aide's performance and the individual's needs, the RN Supervisor shall identify any gaps in the aide's ability to function competently and shall provide training as indicated. The RN Supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

NOTE: Severe cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought process, problem solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

Consumer-Directed (CD) Model

If the CD Service Facilitator is not a registered nurse, the CD Service Facilitator must inform the individual's primary health care provider that services are being provided and request consultation as needed.

The CD Service Facilitator's responsibilities include:

1. Comprehensive Visit: The CD Service Facilitator (CDSF) is responsible for initiating services with the recipient upon accepting the referral of service from the PAS Team or service provider. The CDSF must make an initial comprehensive home visit prior to the start of any care from a personal care aide for any new recipient admitted to CD services. During the visit, the CDSF will identify, with the recipient or family member/caregiver, all individual needs to be addressed in the Plan of Care. The CDSF will develop a safe, appropriate Plan of Care with the recipient that will meet the identified needs of the recipient.

The CDSF will also provide the recipient with a copy of the Employee Management Manual (see the "Exhibits" section at the end of this chapter). The CDSF will ensure that the recipient understands his or her rights and responsibilities in the program and signs all of the Participation Agreements found in the Employee Management Manual (with the Selection of Service, Fiscal Agent, and CD Services Facilitator). These forms must be signed before the recipient can begin employing an aide in the program. The CDSF shall send the original Fiscal Agent Contract to the Fiscal Agent and keep a copy for the recipient's file.

A fiscal (hire) packet must be obtained from the CDSF and given to with the recipient or family member/caregiver. The CDSF should provide needed assistance to ensure its completion.

The initial comprehensive visit is done only once upon the recipient's entry into the service. If a recipient changes CDSFs or the recipient subsequently adds another CD service, the new provider must bill for a reassessment visit in lieu of a comprehensive visit.

2. Consumer (Individual) Training: The CDSF, using the Employee Management Manual, must provide the recipient with training on his or her responsibilities as employer within seven days of the completion of the comprehensive visit (CDSFs can complete the comprehensive visit and individual training in the same day, if appropriate). The CDSF must train the recipient on his or her duties as an employer. To assure that the training content for Employee Management Training meets the acceptable requirements, the CDSF must use, at a minimum, the curriculum provided by DMAS in the "Exhibits" section at the end of this chapter. The CDSF must also follow the checklist outlined in the Consumer-Directed Recipient Comprehensive Training Form. This is an outline of the minimum subjects that DMAS requires the CDSF to cover during the training. The CDSF must check each subject on the form after it has been covered, and have the required signatures and dates. This form must be maintained in the recipient's files and be available for review by DMAS staff. This form can be obtained from the DMAS website and an example can be found in the "Exhibits" section at the end of this chapter.

This training is for the employer of the aide. The CDSF must not offer training of any type to the personal care aide.

3. Routine On-site Visits: After the comprehensive visit, the CDSF must conduct two on-site, routine visits within 60 days of the initiation/comprehensive visit of CD services (once per month) to monitor the recipient's Plan of Care and assess both the quality and appropriateness of the services being provided. After the first two routine on-site visits, the CDSF and recipient can decide how frequent the routine on-site visits will be. However, a face-to-face meeting with the recipient must be conducted at least quarterly for personal care and every six months for respite care when it is provided as a sole service to ensure appropriateness of services. The CDSF must

provide any necessary supervision to the recipient and record all significant contacts in the recipient's file.

During visits with the recipient, the CDSF must observe, evaluate, and consult with the recipient, family member/caregiver, or both and document the adequacy and appropriateness of the CD services with regards to the recipient's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The personal care aide's record may be reviewed, and the recipient's satisfaction with the type and amount of service must be discussed.

If a health and safety issue is noted by the CDSF during a visit, he/she is obligated to report this to the pre-authorization contractor and Child Protective Services/Adult Protective Services, as appropriate.

The CDSF's documentation of this visit may be in the form of a SOAP note (*Subjective* information obtained from the recipient, *Objective* information observed or gathered by the CDSF, *Assessment* as to what can be determined from the subjective and objective information, *Plan* what the best plan is for the recipient), or the CDSF may use a standardized form to record the visit. The "Exhibits" section at the end of this chapter contains an example of the Consumer-Directed Services Individual Assessment Report (DMAS-99). The CDSF must document:

- Whether CD services are adequate to meet the recipient's needs and whether changes to the Plan of Care need to be made;
- Any suspected abuse, neglect, or exploitation and to whom it was reported. This must also be reported to DMAS' Waiver Services Unit at (804) 786-1465;
- Hospitalization or change in medical condition, functioning, cognitive status, or social support;
- The recipient's and/or family member's/caregiver's (as appropriate) satisfaction with services;
- The presence or absence of the aide in the home during the visit;
- Any change in who is employed as the aide. The CDSF must note this in the recipient's file and ensure that the criminal history record check (and Child Protective Services Registry as appropriate) is performed on this new employee;
- Dates of and reasons for any service lapses (hospitalization admission, aide not available, etc.); and
- In addition to the typical information that must be documented in the CDSF's routine visit summary, there are several areas (such as bowel/bladder programs, range of

motion exercises, catheter and wound care, etc.) that, when they are part of an recipient's Plan of Care due to physician's orders, require monitoring by the recipient's primary health care professional or a RN and special documentation by the CDSF of their ongoing completion and the personal care aide's qualifications to perform these tasks (see the "Exhibits" section at the end of this chapter for more details). RN delegation is to be within the scope of 18VAC90-20-420 though 18VAC90-20-460 of the Virginia Administrative Code, which allows an unlicensed person to be supervised and monitored by a RN.

4. Availability: The CDSF must be available by telephone to individuals receiving CD services during normal business hours, have voice mail capability, and return phone calls within 24 hours.

5. Reassessment Visit: Once every six months, the CDSF must meet with the recipient or family member/caregiver to conduct a reassessment of the recipient's current functional and social support status and a complete summary of all services reviewed. Documentation of the reassessment visit must include a complete review of the recipient's needs and available supports and a review of the Plan of Care. The reassessment visit needs to be documented on a DMAS-99. Additionally, the CDSF should conduct a reassessment visit for recipients who are transferring from another CDSF or who request a change in their CD services.

   During visits to the recipient's home, the CDSF shall observe, evaluate, and document the adequacy and appropriateness of personal care services.

   It is appropriate for the aide to chart tasks that are not included in the recipient's Plan of Care if the recipient has a need for the task to be done. The recipient should note why this task was performed and whether the need for this task continues to exist. It is then the responsibility of the CDSF to determine whether there is a need for the task to be included in the Plan of Care on an ongoing basis and make whatever changes are appropriate.

6. Monitoring: The CDSF is responsible for counseling a recipient regarding his or her responsibilities as an employer; requesting from the pre-authorization contractor an increase/decrease to the recipient's Plan of Care as needed; consulting with the recipient or family member/caregiver as needed; discussing with the recipient the need for additional CBC services; or contacting DMAS to request a special review of the recipient's case. Anytime the CDSF is unsure of the action that needs to be taken, the provider should contact the Waiver Services Unit at DMAS.

   If the CDSF determines that the health, safety, and welfare of the recipient may be in jeopardy, the CDSF is responsible for recommending the recipient's discharge from waiver services.

7. Management Training: This training is provided by the CDSF upon the request of the recipient or family member/caregiver. This may be additional management training for the recipient or family member/caregiver. The CDSF must not use this to train the employee.

   Management training can also be used to reimburse the CDSF for the costs of tuberculosis screening, cardiopulmonary resuscitation certification, and annual flu immunizations. The CDSF can bill DMAS for the costs of these requirements on behalf of the recipient by billing for these costs in management training units and maintaining documentation of these costs in the recipient's file.

8. Criminal Record Check: All CD aides must complete a criminal record check. CDSFs assist recipients by submitting the criminal record check forms on the aide to the Virginia State Police on behalf of the aide prior to the start of CD services and whenever the recipient hires a new aide. CDSFs will also pay the fee for a criminal record check on behalf of the recipient, and DMAS will reimburse CDSFs for the cost of the criminal record check for up to six record checks per recipient within any six-month period of time. The CDSF will provide the recipient or family member/caregiver with the results of the criminal history record request and document in the recipient's record that the recipient or family member/caregiver has been informed of the results of the criminal record check. If the aide has been convicted of crimes described in 12 VAC 30-90-180, the aide will no longer be reimbursed under this program for services provided to the recipient effective the date the criminal record was confirmed. The CDSF is also responsible for notifying the Fiscal Agent whenever an aide is found to have been convicted of any of the applicable crimes. (See the "Exhibits" section at the end of this chapter for a listing of applicable crimes).

   If the aide is providing CD personal care or CD respite services to a recipient under 18 years of age, the aide must be screened through the DSS Child Protective Services Central Registry. If the registry confirms a complaint on the aide, the aide will no longer be reimbursed under this program for services provided to the recipient effective as of the date the child protective services registry was confirmed.

   Recipients have the right to choose, hire, and employ an aide whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code (12 VAC 32.1-162.9:1), as may be amended from time to time. When doing so, recipients and family members/caregivers must understand this decision and that the consequences thereof are their sole responsibility.

9. Verification of Time sheets: The CDSF must send the completed DMAS-122 by mail or fax to the Fiscal Agent for use in processing time sheets. The CDSF shall review copies of the time sheets (if copies are available) during routine on-site visits to ensure that the hours of service provided are consistent with the Plan of Care. If the recipient, acting as the employer, is unable to sign the time sheet and no other family

member/caregiver is able to sign, the recipient may make an "X." If the recipient is unable to sign or make an "X," the CDSF must make a notation in the front of the recipient's record that "recipient is unable to sign."

If discrepancies are identified in the time sheets, the CDSF must contact the recipient or family member/caregiver to resolve discrepancies and must notify the Fiscal Agent. If an aide consistently has discrepancies in his or her time sheets and training has been offered, the CDSF must meet with the recipient or family member/caregiver to determine if CD services remain appropriate (i.e., that the recipient or family member/caregiver can manage the services).

CD Services Payroll Function

The CDSF will perform certain tasks as an agent for the recipient who is receiving CD services (as the employer of the aide). The CDSF will provide a packet of employment information and necessary forms to the recipient or family member/caregiver. The forms must be completed and returned to the Fiscal Agent before the aide can be employed. The Fiscal Agent will handle responsibilities for the recipient for paying the aide and the related employment taxes. The Fiscal Agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to complete these duties. The time sheet is sent to the Fiscal Agent (with a copy kept for review by the CDSF) by the recipient or family member/caregiver biweekly.

Please refer to the Consumer-Directed Services Hire Packet in the Appendices of this chapter for more information on CD services.

PERSONAL CARE SERVICES: AGENCY- AND CONSUMER-DIRECTED

Personal care services means direct assistance with activities of daily living (ADLs), instrumental activities of daily living, and monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable a recipient to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The recipient must require assistance with ADLs in order for personal care services to be authorized.

Response To Inappropriate Authorization Services

The provider should not initiate services if the RN/CDSF determines one of the following during the initial assessment:

- The recipient is not appropriate for EDCD Waiver services due to health, safety, and welfare concerns;
- The provider cannot manage the recipient's care; or

- An appropriate Plan of Care cannot be developed to meet the recipient's needs.

If the RN or CDSF determines that he/she should not initiate services, the provider/CDSF must notify the eligibility worker at DSS and the Level-of-Care Review Analyst at DMAS of this decision immediately. The provider/CDSF is responsible for providing DMAS with the documentation supporting its decision. If DMAS agrees that the provider/CDSF should not start services, DMAS will send a letter of notification to the recipient informing him/her of this and provide appeal rights.

The recipient will have 30 days to appeal the DMAS decision. Copies of the DMAS letter to the recipient will be sent to the provider and the PAS Team.

If DMAS disagrees with the provider's/CDSF's decision not to initiate care, DMAS will contact the agency/CDSF in writing and inform them that services can be initiated.

If the provider does not initiate care because of the provider's inability to staff the case adequately, the provider must assist the recipient with locating another provider. If there is no provider available in the community that is available to staff the case, the provider must inform the recipient of this in writing. Providers should, however, explore the possibility of ADHC, CD services, or AD services as an alternative service.

If a provider/CDSF is not sure that a recipient meets the level-of-care eligibility criteria for the EDCD Waiver, the provider/CDSF must request a level-of-care referral to the Level-of-Care Review Analyst at DMAS. The provider/CDSF should initiate and provide services while DMAS is conducting the level-of-care review. If it is determined by DMAS that the recipient does not meet level-of-care eligibility, DMAS will send a letter of notification to the recipient, the provider, and DSS informing them of the decision and provide appeal rights to the recipient. DMAS will reimburse providers/CDSFs for providing services rendered up to the termination date decided on by DMAS.

Service Units and Limitations

The unit of service for personal care services is one hour. Payment is available only for allowable activities that are authorized and provided by a qualified provider in accordance with an approved Plan of Care when the recipient is present. Personal care services are limited to the hours specified in the Plan of Care.

Allowable Activities

The allowable activities for personal care services include:

1. Assistance with activities of daily living (ADLs) such as: bathing or showering, toileting, dressing, transferring, etc.;

2. Assistance with monitoring health status and physical condition;

3. Assistance with self–administration of medication (not to include in any way determining the dosage of medication) and other medical needs;

4. Assistance with preparation and eating of meals (preparation of only the recipient's meal is allowed);

5. Assistance with housekeeping activities, such as bed making, dusting, vacuuming, laundry, and grocery shopping, etc., when specified in the recipient's Plan of Care and essential to the recipient's health or welfare, or both;

6. General support to assure the safety of the recipient;

7. Providing routine skin care, such as applying lotion to dry skin, not to include topical medications or any type of product with an "active ingredient";

8. Assistance and support needed by the recipient to assure safety and allow the recipient to participate in social, recreational, and community activities;

9. Accompanying the recipient to appointments or meetings when personal care is needed;

10. Administration of bowel programs by the aide under special training and supervision. The personal care aide may be authorized to administer physician-ordered bowel programs to recipients who do not have any other support available. This authorization can only be given if the provider has documented (i) the aide has received special training in bowel program management, (ii) the aide has knowledge of the circumstances that require immediate reporting to the RN Supervisor, and (iii) the RN Supervisor has observed the aide performing this function. (This requirement applies to substitute aides as well.)

    Certain conditions exist that would contraindicate having the aide perform a bowel program (i.e., patients prone to dysreflexia such as high level quadriplegics, head and spinal cord injured patients, and some stroke patients). The bowel program may include, if necessary, a laxative, enemas, or suppositories to stimulate defecation. However, the laxative cannot be "administered" by the aide, even though part of the bowel program. (Suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy

bag as part of the bath is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted. The above procedures must only be administered with a physician order. A new physician's order must be obtained every six (6) months or more frequently if changes in the recipient's condition occur.

The RN Supervisor must be available to the aide and be able to respond to any complications immediately;

11. Administration of range-of-motion (ROM) exercises by the aide when instructed and supervised by the RN Supervisor. A physician must order ROM exercises every six (6) months or more frequently if changes in the recipient's condition occur. This order from the physician must specify that the recipient requires ROM and the frequency to be administered. The aide may perform ROM when the aide has been instructed by the RN Supervisor in the administration of ROM exercises, and the aide's correct performance of these exercises has been witnessed and documented by the RN Supervisor/CDSF. Documentation must state that the aide is trained in the performance of these exercises, and is competent in performing the ROM exercises. (This requirement applies to substitute aides as well.) This does not include strengthening exercises, resistance exercises, or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance. The RN Supervisor will check the ROM on the supervisory visits and will make adjustments to the exercises as often as necessary according to the physician's orders;

12. Routine wound care by the aide, which does not include sterile technique. A physician must order wound care (even routine) every six (6) months or more frequently if changes in the recipient's condition occur. The aide can perform routine wound care, which does not include sterile treatment or sterile dressings. This includes care of a decubitus, which is superficial or does not exceed Stage I. Normal wound care includes washing the area, drying the area, and applying dry dressings as instructed by the RN Supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings (such as hydrocolloids and transparencies).

    NOTE: Whenever an aide is performing any physician-ordered procedure, the RN must document on the DMAS-99 that the aide's correct performance of the procedure is being observed and supervised by the RN Supervisor. This must be documented at least quarterly;

13. Checking the temperature, pulse, respiration, and blood pressure and recording and reporting as required;

14. Home Maintenance Activities: These activities, which are related to the maintenance

of the home or preparation of meals, should only be included in the Plan of Care for recipients who do not have an available caregiver. Caregivers living in the home with the recipient, who would be expected to perform housekeeping and cooking activities for themselves, should provide the recipient's home maintenance activities while completing their own. However, this should be done on a case-by-case basis taking into account whether the caregiver is willing and able to perform these activities. For recipients who do not have someone either living in the home or routinely coming in to provide assistance, the following activities may be performed for the recipient only (not for other members of the family):

- Preparing and serving meals, not to include menu planning for special diets;
- Washing dishes and cleaning the kitchen;
- Making the bed and changing linens;
- Cleaning the recipient's bedroom, bathroom, and rooms used primarily by the recipient;
- Listing for purchase supplies needed by the recipient;
- Shopping for necessary supplies for the recipient if no one else is available to perform the service; and
- Washing the recipient's laundry if no other family member is available or able.

DMAS will pay the provider only for services rendered to the recipient. DMAS will not pay the provider for services rendered to or for the convenience of other members of the recipient's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.);

15. Supervision is a covered service within the personal care Plan of Care when the purpose is to supervise or monitor those recipients who require the physical presence of the aide to ensure their safety during times when no other support system is available. The inclusion of supervision in the Plan of Care is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. This includes recipients who cannot use a telephone to call for help due to a disability.

    Supervision will not be authorized for family members to sleep either during the day or during the night unless the recipient cannot be left alone at any time. Supervision cannot be considered necessary, because the recipient's family or provider is generally concerned about leaving the recipient alone or would prefer to have someone with the recipient. There must be a clear and present danger to the recipient as a result of being left unsupervised. Supervision cannot be authorized for persons whose only need for

supervision is for assistance exiting the home in the event of an emergency but may be authorized if there is no one else in the home competent to call for help in an emergency.

A personal/respite care aide is allowed to provide supervision to recipients who are on ventilators, or continuous tube feedings, or who require suctioning. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-20-420 through 18VAC90-20-460. This includes recipients who are receiving morphine through a pump. The aide is not allowed to push the button on a pump to release the pre-measured dose of morphine, because this is interpreted as the delivery of medication, which is not a covered service for personal/respite aides. For provision of these services, the personal/respite care aide must be trained by a nurse and such training documented by the RN.

If the recipient's primary caregiver has a business in the home, such as a day care center, supervision will only be considered if the recipient is documented as being dependent in orientation and behavior pattern on the UAI and/or documented on the DMAS-99.

The amount of supervision time in the Plan of Care must be no more than is necessary to prevent physical deterioration or injury to the recipient, but in no case can more than eight hours per day be authorized. PERS may be explored in lieu of supervision; and

16. For CD services, attending training requested by the recipient or family member/ caregiver that relates to services described in the Plan of Care.

Attending To Personal Care Needs Of Recipients During Work Or Post-Secondary School

Recipients who receive EDCD Waiver services may work or attend post-secondary school, or both, while receiving services under this waiver. The personal care aide may accompany the recipient to work/post-secondary school and may assist the recipient with personal care needs while the recipient is at work/post-secondary school.

DMAS will not pay for the aide to assist the recipient with functions related to the recipient completing his or her job/school functions or for supervision time during work or post-secondary school, with the exception of physical assistance provided due to the recipient's inability to perform this function due to disability.

The pre-authorization contractor will review the recipient's needs when determining the services that will be provided to the recipient in the workplace/post-secondary school. The provider must develop an individualized Plan of Care that addresses the recipient's needs at home, work, or in the community.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the recipient's only need is for assistance during lunch, DMAS would not pay for the aide for

any time extending beyond lunch. For an recipient whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the recipient is physically unable to speak or make herself/himself understood even with a communication device, the aide's services may be necessary. DMAS will pay for the aide's services unless the aide is required to assist the recipient as a part of the ADA, or the Rehabilitation Act of 1973.

DELEGATION OF SKILLED SERVICES

Personal care services shall not include either practical or professional nursing services as defined in the Nurse Practice Act with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18 VAC 90-20-420 and 18 VAC 90-20-460, with such delegated tasks being reimbursable under Home Health services. Examples of these services include those that require professional skills such as Foley catheter irrigations, suctioning, sterile dressings, or any other procedures requiring sterile technique. The RN Supervisor is responsible for identifying and assessing if the personal care aide is capable of performing the skilled nursing activity. If the RN Supervisor delegates this activity to a personal care aide, the provider agency must maintain the following documentation:

- The name of the RN Supervisor, a copy of the RN Supervisor's current license, and license number;
- The specific tasks that are to be delegated to the aide;
- A description of the instruction given to the aide, and confirmation by the RN Supervisor that the personal care aide has been witnessed successfully giving the care;
- Review notes by the RN Supervisor demonstrating the delegated activity is monitored and supervised by the RN at least every 30-90 days, or more often if determined appropriate; and
- Physician's order for the service(s).

DEVELOPMENT OF THE PLAN OF CARE (DMAS-97A/B): AGENCY- AND CONSUMER-DIRECTED

The DMAS-97A/B must be completed by the provider's RN/CDSF prior to the start of care for any recipient. The PAS Team's Plan of Care indicates to the provider/CDSF the general needs of the recipient. The provider/CDSF should allocate time for the four service categories (which include 19 specific personal/respite care tasks) listed on the DMAS-97A/B. The RN Supervisor's/CDSF's assessment visit should note any special considerations for service provision and the support available to the recipient. Time does not need to be allocated for each of the 19 tasks on the Plan of Care; these should only be checked or a description given, if necessary. Each sub-category should be totaled if time has been allotted to that category (Activities of Daily Living, Special Maintenance, and Housekeeping).

Each recipient is assigned a level of care based on his or her composite ADL score. The composite ADL score is the sum of a rating of the ADL categories. These categories are bathing, dressing, transfers, ambulation, eating, toileting, and continence. The provider/CDSF should assign a rating for each ADL category that best describes the recipient based on the RN's/CDSF's observation at the time of the initial home evaluation. The score for each of these categories can be found at the end of this Chapter under Pre-Admission Screening Criteria For Nursing Home Care. Once the recipient's composite score is derived, a level of care is designated for that recipient as a Level A, B, or C. The designation of a level of care is important because the level of care determines the **maximum** number of hours per week of personal care services that the recipient may have allocated to his or her Plan of Care. **Any hours beyond the maximum for the recipient's level of care must be pre-authorized by the pre-authorization contractor.** Any Plan of Care submitted without approval for hours beyond the **maximum** for any particular level of care will only be entered for the **maximum** for that level of care. Once the pre-authorization contractor authorization is received, the number of hours can be increased. However, the increase in hours will not be made retroactive. Each level-of-care category has a **maximum** amount of hours for that level. The categories, composite scores, and **maximum** hours are as follows:

LOC A
(score 0-6)
Maximum Hours - 25 per week

LOC B
(score 7-12)
Maximum Hours - 30 per week

LOC C
(score 9+ wounds, tube feedings, etc.)
Maximum Hours - 35 per week

Prior to designating the level of care, however, the provider/CDSF should develop the Plan of Care to reflect the needs of the recipient and not necessarily the **maximum amount** of service that the recipient is able to have based on his or her level of care. This **maximum** is based on a seven-day-per-week Plan of Care. The provider/CDSF is allowed to develop a Plan of Care and subsequently make changes to the Plan of Care without prior approval from the pre-authorization contractor as long as the recipient's amount of service does not exceed the **maximum amount** established for that recipient's level of care and as long as supervision is not being added as a new service. The provider/CDSF must submit to the pre-authorization contractor the change of hours for billing purposes. Reimbursement for the full amount of services included in the Plan of Care and rendered by the provider/CDSF may be denied when the recipient's Plan of Care is inflated beyond the needs of the recipient.

Level of Care A - The recipient's score is 6 or less on the ADL composite rating and the recipient has medical/nursing needs. Recipients in Level of Care (LOC) A are the most functionally capable group in personal/respite care and, therefore, should usually require the least

amount of services (anywhere from 7.5 to 17.5 hours per week). The **maximum amount** of time per week that a recipient in LOC A may be provided services has been established at 25 hours per week. This **maximum** is based on a seven-day-per-week Plan of Care with an average daily need for ADL care of two (2) hours/day and housekeeping of one and one half (1.5) hours per day. Although the provider/CDSF may use the **maximum** allowed for the level of care, it is expected that recipients will not routinely require **maximum amounts** of care. Within the level of care, the amount of time required to perform ADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider/CDSF to determine the appropriate allocations of ADL time for recipients within LOC A.

1. Minimal Needs - These are the least dependent recipients, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The recipient may require prompting rather than hands-on assistance, may use mechanical help more than human help with a need for standby assistance:

   Suggested time allocated for ADLs - .75 - 1 hour/day
   Suggested time for Housekeeping - 1 - 1.5 hours/day

2. Average Needs - These recipients have somewhat more need for hands-on help, standby assistance, and are somewhat more dependent (ADL score 3-4):

   Suggested time allocated for ADLs - 1 - 1.5 hours/day
   Suggested time for Housekeeping - 1 - 1.5 hours/day

3. Heavy Needs - These recipients will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

   Suggested time allocated for ADLs - 1.5 - 2 hours/day
   Suggested time for Housekeeping - 1 - 1.5 hours/day

Level of Care B - The recipient's score is between 7-12 on the ADL composite rating and has a medical nursing need. These recipients will probably require an average of from 15 to 28 hours per week. The **maximum amount** of time per week that a recipient in LOC B has been established at 30 hours per week, with an average daily need for ADL care of 2.5 hours/day and housekeeping of 1.75 hours per day. This **maximum** is based on a seven-day-per-week Plan of Care. Although the provider/CDSF may use the **maximum** allowed for the level of care, it is expected that recipients will not routinely require **maximum amounts** of care.

The following guidelines are intended to assist the provider/CDSF to determine the appropriate allocations of ADL time for recipients within LOC B. Within this level of care, the amount of time required to perform ADL and housekeeping will vary. Recipients in LOC B probably require between the heavy time allocated in LOC A and an average amount of time for housekeeping tasks.

1. Minimal Needs - These recipients may require assistance to ambulate, but are still able to perform some tasks for themselves (ADL score 7-8):

   Suggested time allocated for ADLs - 1.5 - 2 hours/day
   Suggested time for Housekeeping - 1 - 1.75 hours/day

2. Average Needs - These recipients may require assistance to transfer as well as ambulate, eat, toilet, most ADLs (ADL score 9-10):

   Suggested time allocated for ADLs - 2 - 2.5 hours/day
   Suggested time for Housekeeping - 1 - 1.75 hours/day

3. Heavy Needs - These recipients will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and, therefore, may actually take less time to render services than the recipient who performs some self-care but requires assistance (ADL score 11-12):

   Suggested time allocated for ADLs - 1.5 - 2.5 hours/day
   Suggested time for Housekeeping - 1 - 1.75 hours/day

Level of Care C - The recipient's score is 9 or more on the ADL composite rating and in addition has a skilled medical/nursing need. Examples of skilled needs are wound care (greater than Stage I decubitus), tube feedings, trach care, suctioning, and ventilator care. Note: These needs merely qualify a recipient to be rated as LOC C. Personal care aides cannot participate in assisting recipients with these needs, with the exception of tasks delegated pursuant to the Nurse Practices Act and Virginia Administrative Code 18VAC90-20-420 through 18VAC90-20-460. Recipients in LOC C are the least functionally capable group and must have skilled medical/nursing needs. These recipients will probably require an average of from 20 to 30 hours per week. The recommended amount of time per week that a recipient in LOC C may be provided services has been established at 35 hours per week, with an average daily need for ADL care of three (3) hours per day and housekeeping of two (2) hours per day. Although the provider/CDSF may use the **maximum** allowed for the level of care, it is expected that recipients will not routinely require **maximum amounts** of care.

The following guidelines are intended to assist the provider/CDSF with determining the appropriate allocations of ADL time for recipients within LOC C. Within this level of care, the amount of time required to perform ADL and housekeeping tasks may vary.

1. Minimal Needs - These recipients may have the **maximum** in-home support and fewer special maintenance needs. Some of the recipients in this minimum range of needs within LOC C will actually be quite dependent, but may be cared for quickly merely because they do not participate in their own care:

   Suggested time allocated for ADLs - 1.5 - 2 hours/day
   Suggested time for Housekeeping - 1 - 2 hours/day

2. Average Needs - These recipients will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:

   Suggested time allocated for ADLs - 2 - 3 hours/day
   Suggested time for Housekeeping - 1 - 2 hours/day

3. Heavy Needs - These recipients may be new quadriplegics, have a degenerative disease and generally will be the most difficult recipients to maintain in their homes due to their many maintenance needs:

   Suggested time allocated for ADLs - 2 - 3 hours/day
   Suggested time for Housekeeping - 1 - 2 hours/day

Supervision

The **maximum amount** of care established for all levels of care were not established with regard to the need for supervision as a personal/respite care task. A recipient in any level of care may require 24-hour-a-day supervision due to confusion, disorientation, wandering or aggressive behavior, or inability to remain safely alone due to physical condition and social support. Additional time can be added to the Plan of Care beyond the **maximum amount** of time for that recipient's level of care, but this Plan of Care requires prior authorization from the pre-authorization contractor before it can be initiated. Personal Emergency Response Systems (PERS) may be an appropriate service for a recipient who requires supervision. PERS may only be provided to recipients who, if not for the service, would require supervision. PERS should only be used to replace supervision, not add to it.

If the recipient requires more supervision and time beyond that which is provided through the personal care time allowed for ADLs and housekeeping, and the provider/CDSF is requesting time for supervision, the recipient must have a support system that is willing and able to provide those additional supervision needs. Recipients who have supervision time in the Plan of Care must have someone with them 24 hours a day. The provider/CDSF must document on the DMAS-99 the need for supervision and the plan for the recipient's care during times when the aide will not be in the home. The provider must document this information on the DMAS-99. If supervision time is included in the recipient's Plan of Care, the RN Supervisor/CDSF must document this information on the DMAS-100 (Request for Supervision Form).

It is important to recognize that the guidelines provided reflect the way in which the pre-authorization contractor will review Plans of Care submitted. However, since the level of care does not reflect the medical needs of the recipient as per the diagnosis and recent history or reflect the idiosyncrasies of that recipient's personality or environment, the guidelines cannot fully capture the range of needs and support that the provider may encounter. For instance, housekeeping needs will vary according to the abilities of the recipient as reflected in the level of care and according to the amount of social support received from either a live-in caregiver or some other family or community support. The amount of time required for housekeeping may

also be affected by other factors, such as the presence of on-site laundry facilities, the lack of modern plumbing, heating, and cooking facilities. It is, however, only in very unusual circumstances that a Plan of Care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances should be clearly documented on the DMAS-97A/B. The provider is expected to use professional judgment to determine the amount of service needed by the recipient. Documentation must support the amount of hours provided to the recipient.

Changes To The Plan of Care

The provider is responsible for making modifications to the Plan of Care as needed to ensure that the aide and recipient (or family) are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the recipient.

Any time the number of hours, for a recipient, need to be changed, the provider must develop a new Plan of Care. The most recent Plan of Care must always be in the recipient's home. The provider must either complete a new Plan of Care at least annually or document on the current Plan of Care (DMAS 97A/B) annually that the Plan of Care was reviewed and no changes are necessary. If there are no changes to this annually updated Plan of Care, there is no need to send it to the pre-authorization contractor. Copies of all Plans of Care must be maintained in the recipient's file. These Plans of Care and documentation of service delivery must be consistent with the information submitted to the pre-authorization contractor or communicated to the pre-authorization contractor by telephone when contacted for an authorization.

Changes of hours must be submitted to the pre-authorization contractor, using the DMAS-98, Community-Based Care Request for Services Form (found in the "Exhibits" section at the end of this chapter). The provider may document the increase/decrease within the level of care directly on the DMAS-98. However, if the hours are crossing the recipient's current level of care, (the recipient was a level-of-care A, and is now a level-of-care B; or a level-of-care B and is now a level-of-care C and in need of increased hours), the provider must submit to the pre-authorization contractor the new Plan of Care reflecting the revised hours and updated composite ADL score reflecting the change in level of care. It should be noted that it is at the pre-authorization contractor's discretion to request Plans of Care, or any supporting documentation at any time to support the analysts' decisions. Providers are required to submit changes in hours when they occur. Do not submit changes in hours at the end of the month. Always use the CBC Request for Services Form (DMAS-98) when submitting any request. The monthly-change-in-hour forms should not be utilized or submitted to the pre-authorization contractor.

The provider must follow the procedures to request an authorization whenever a change in the recipient's condition (physical, mental, or social) indicates that:

- The recipient requires supervision to be added to the Plan of Care even if the recipient's hours will be within the level-of-care category (pre-authorization is not required if supervision is authorized on the DMAS-97 and hours do not exceed level-of-care category); or

- An increase in the Plan of Care is needed for more than the amount allowed according to the recipient's current level of care.

When it is identified, either upon admission of a new recipient or after services have been initiated, that a recipient requires a change to the Plan of Care, as outlined above the providers involved in the recipient's care must consult with each other to coordinate the changes to the recipient's Plan of Care. This communication must be documented in each provider's recipient records.

The provider may contact the pre-authorization contractor, CBC Review Unit at 804-648-3159 in Richmond, or 1-800-299-9864 in all other areas, and speak to the review analyst. The provider may also fax or mail the request. The provider must have the following information available in order to discuss the case with the review analyst:

-Name of requesting provider
-Name and ID # of provider
-Address of provider
-Total weekly hours requested for the new Plan of Care and the reason the hours are needed
-Name of recipient
-Recipient's Medicaid number
-Current hours on the Plan of Care
-Effective date being requested for the new Plan of Care

The provider must be thoroughly familiar with the recipient's condition and the recipient's social support system. If supervision is being requested while the caregiver works, the provider may be asked to obtain a note from the caregiver's employer verifying the work schedule.

The provider must document the discussion with the pre-authorization contractor analyst. This provider documentation must include the time and date of the call, the name of the analyst to whom the provider spoke, and the outcome decision from the conversation. If the pre-authorization contractor analyst has requested additional information and not yet approved the hours or services, that, too, should be documented.

If supervision time is being requested for AD or CD personal care, the RN Supervisor/CDSF must complete the two-page Request for Supervision Form (DMAS-100). This form must be completed for each recipient who has time allotted in the supervision category on the Plan of Care. This Supervision Request Form and Plan of Care must be faxed or mailed to the pre-authorization contractor. The most recent RN Supervisor/CDSF visit (DMAS-99) may also be required.

The pre-authorization contractor staff will enter authorizations or denials into the First Health system. Once the entry has been made, the provider and recipient will receive a computer-generated letter from First Health Services notifying them of the decision and providing appeal rights if a denial is issued. Recipients have the right to appeal any adverse action taken by the pre-authorization contractor. A copy of this letter must be maintained in the recipient's record. If a denial is issued, the provider will also be notified via fax by the pre-authorization contractor.

All provider issues for the pre-authorization contractor CBC Review Unit will be handled by the analyst(s) assigned to telephone duty on the day the call comes in.

Personal Care Split-Shift Service Delivery (Agency- and Consumer-Directed)

There are situations in which the recipient may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). The provider must complete two Plans of Care, labeled morning or afternoon, to indicate each shift of services. The total number of hours on morning and afternoon Plans of Care combined cannot exceed the number allowed for the recipient's level of care without prior approval from the pre-authorization contractor.

Scheduled Services Not Provided

The personal care aide is responsible for following the current Plan of Care as outlined in the Provider Agency Plan of Care (DMAS-97A/B). If the aide does not work the total number of hours during a scheduled day, as it is listed on the DMAS-97A/B, the aide may use the unused hours on another day within that same week only if:

1. The recipient and/or primary caregiver requests that the unused time be used on another day of that week; and

2. The reason for the hours to be carried over to another day is for extraordinary circumstances that cannot be accommodated by the Plan of Care, and the leftover time is needed to meet the needs of the recipient. The need must be documented by the aide on the Provider Aide Record (DMAS-90) and by the RN in the recipient's record. The reason cannot be to allow the aide to make up the unused hours of the week; and

3. The total amount of hours worked during the week do not exceed the number of authorized hours for the week on the DMAS-97A/B.

An example when the aide can make up the hours on the POC: A recipient has an authorized Plan of Care (DMAS-97A/B) for services Monday through Friday, six hours per day, which is 30 hours of personal care per week. Inclement weather prevents the aide from reaching the residence on Wednesday of one week. The family requests that the aide come out on Saturday of the same week to work the 6 hours that was not used on Wednesday. The agency is contacted by the recipient before Saturday to request that the aide come in Saturday to assist with personal care tasks.

An example when respite is appropriate: A recipient has an authorized Plan of Care (DMAS-97A/B) for services Monday through Friday, six hours per day, which is 30 hours of personal care per week and relies on a primary, unpaid caregiver for his/her personal care on weekends. The aide does not work the entire 30 hours by the end of the week and the caregiver will be out of the home on Saturday or he/she needs temporary relief from providing care on Saturday. The recipient will need personal care services in the caregiver's absence. Since the need for aide's

services is for the temporary relief of the caregiver that is outside the authorized Plan of Care, the caregiver must contact the agency and request respite care services. If the recipient currently does not have authorization for respite care services, authorization must be obtained from the pre-authorization contractor prior to the aide rendering respite care on Saturday. If respite services are already authorized, the caregiver must contact the provider agency to request respite services on Saturday.

SUPERVISION OF PERSONAL CARE AIDES: AGENCY-DIRECTED (AD) MODEL

The RN must provide supervision of personal care aides. The RN Supervisor must offer quarterly in-service training totaling a minimum of 12 hours within a calendar year. Another qualified provider of such training may provide this in-service instruction, but the provider must offer in-service training that is appropriate in content and is offered to all staff providing personal care. The RN Supervisor or other appropriate agency personnel must provide in-service training (to include Medicaid requirements, policies, and overall aide responsibilities) to all personal care aides prior to their assignment to a Medicaid recipient, and must document the training in the aide's personnel file.

The aide must be present during the RN Supervisor's visit at least every other visit. If the aide is present during all supervisory visits, the RN Supervisor must contact the recipient by telephone during non-personal care hours to assess the recipient's satisfaction with services. This telephone contact must be documented in the recipient's record.

When a split-shift service is provided and a different aide is working on each shift, the RN Supervisor must alternate the supervisory visit between both shifts in order to provide supervision to each aide. Also, if weekend or night service is the only time when the services are provided (example: 11:00 p.m. until 7:00 a.m.), the RN Supervisor must make a visit at least every other month during the time the aide is working. If the recipient is also receiving services during the day hours, and the aide that is providing the weekend or night services is different than the weekday aide, the RN Supervisor can make the supervisory visit during the weekday and discuss the other shifts with recipient.

A RN Supervisor must be available to the aides by telephone at all times that an aide is providing services to a recipient. A provider may contract with a RN Supervisor to provide this service or find other means to meet this requirement since the provider cannot be without a RN Supervisor. Ongoing assessment of the aide's performance by the RN Supervisor is also expected to ensure the health, safety, and welfare of the recipient.

SUPERVISION OF PERSONAL CARE SERVICES – CONSUMER-DIRECTED (CD) MODEL

The CDSF is responsible for monitoring the ongoing provision of services to each Medicaid recipient. This monitoring includes:

- The quality of care received by the recipient;

- The functional and medical needs of the recipient and any modification necessary to the Plan of Care due to a change in these needs; and

- The recipient's needs for support in addition to the care provided by personal care services. This includes an overall assessment of the recipient's safety and welfare in the home with personal care services.

INABILITY OF AN AIDE TO PROVIDE SERVICES AND SUBSTITUTION OF AIDES: AGENCY-DIRECTED (AD) MODEL

If a provider cannot supply an aide to render authorized services, the provider may either obtain a substitute aide from another provider, if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the recipient's services to another provider. If the provider obtains a substitute aide from another agency, the two providers are responsible for negotiating the financial arrangements of paying the substitute aide.

When a substitute aide is secured from another provider, the following requirements apply:

- The pre-authorized provider is responsible for providing the supervision for the substitute aide;

- Only the pre-authorized provider may bill DMAS for services rendered by the substitute aide;

- The pre-authorized provider must ensure that all DMAS requirements continue to be met;

- The provider having recipient responsibility must provide the RN supervision for the substitute aide;

- The agency providing the substitute aide must send to the provider having recipient care responsibility a copy of the aide's daily records signed by the recipient and the substitute aide. All documentation of services rendered by the substitute aide must be in the recipient's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the responsible provider; and

- If a provider secures a substitute aide, the provider is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS' requirements. The provider having recipient care responsibility will bill DMAS for services rendered by the substitute aide. The two agencies involved are responsible for working out the financial arrangement of paying the substitute aide.

Substitute aides obtained from other providers should be used only in cases where no other arrangements can be made for personal care services coverage, and should be used on a

temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another provider that has the aide capability to serve the recipient(s).

If no other provider can supply an aide, the provider shall notify the recipient or family and explain the possible availability of CD services or ADHC. Pre-authorization is required in those cases in which the services are transferred to another provider or to CD services.

Some recipients take turns staying with different relatives throughout the year in different parts of the state. Rather than transferring a case back and forth, one primary provider (which could be an ADHC or a personal care provider) may contract with a provider in another city or county to provide services. In that event, the same procedure should be followed for obtaining a substitute aide.

Respite Care

Respite services are personal care (AD or CD) or services of a nurse (AD) that are specifically designed to provide temporary, substitute care that is normally provided by the family or another unpaid, live-in primary caregiver of a recipient. Respite is for the relief of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the recipient. These services are provided on a short-term basis because of the emergency absence, or need for routine or periodic relief, of the primary caregiver who lives in the home with the recipient. In the situation when several caregivers take turns staying at night with the recipient, respite care cannot be used because none of these individuals is the live-in primary caregiver.

The maximum amount of combined respite care services that a recipient may receive is 720 hours in a calendar year. Recipients who are receiving CD, AD, and facility-based respite services cannot exceed 720 hours per calendar year combined. For AD respite care, the personal care agency is responsible for tracking the number of hours used. If the recipient is using both AD and CD respite services, the CDSF and the personal care agency must coordinate the tracking of the respite care hours used. Respite care must be authorized by the pre-authorization contractor before being rendered. If more than 720 hours per year are provided, DMAS will only pay for the first 720 hours that are billed.

Recipients who exhaust their maximum amount of hours prior to the end of the authorization period must be informed that no additional hours will be authorized. In these cases, they must wait until the calendar year has expired. The provider must ensure that the recipient continues to meet the criteria, as stated above, to receive respite services.

Respite care services are usually provided by a personal care aide. However, a licensed nurse may provide respite in cases where the recipient has a skilled nursing need, provided there is a physician order for the services that will be provided. Respite care can be authorized as a sole community-based care service, or it can be offered in conjunction with other waiver services. Medicaid payment is available only for services authorized and provided according to the Plan of Care and provided by a qualified provider.

Supervision of Respite: Agency-Directed (AD) Model

a. When respite services are received, the minimum acceptable frequency of these supervisory visits shall be every 30-90 days based on the needs of the recipient.

b. When respite services, as a sole service, are episodic in nature, the supervisor is not required to conduct a supervisory visit every 30-90 days. Instead, the supervisor must conduct the initial home visit with the personal care aide immediately preceding the start of services and make a second home visit within the respite service period.

c. When respite services are offered in conjunction with personal care, the 30-90 day supervisory visit conducted for personal care may serve as the supervisory visit for respite. The RN must document on the DMAS-99 whether respite is being used and why. The RN Supervisor must document this on the DMAS-99 that the supervisory visit is for both personal care and respite care. This documentation may be kept in one record. If a separate record is used for both personal care and respite care, the DMAS-99 must be in each record. However, the supervisor must document supervision of respite services separately. For this purpose, the same individual record may be used with a separate section for respite services documentation.

RN Supervision of the Personal Care Aide

RN supervision of the personal care aide must include the following:

1. The RN Supervisor must make an initial assessment visit on or prior to the start of respite services for any recipient authorized for respite as a sole service. The RN Supervisor must also perform any subsequent reassessments or changes to the supporting documentation;

2. The RN must make supervisory visits as often as needed to ensure both quality and appropriateness of services; and

3. Based on continuing evaluations of the aide's performance and the recipient's needs, the RN Supervisor shall identify any gaps in the aide's ability to function competently and shall provide training as indicated.

Skilled Respite Care (Agency-Directed Only)

Through the respite care program, the provider may be paid for the services of a nurse currently licensed to practice in the Commonwealth of Virginia as long as the provider can document circumstances requiring the provision of services by a licensed nurse. DMAS will reimburse for this respite care for those recipients who require the skilled level of care and who have no support system other than the primary caregiver. The circumstances warranting provision of respite care by a nurse are:

- A physician's order must be obtained prior to the start of skilled respite services and must be kept in the recipient's record. The order must be renewed every six (6) months;
- The recipient receiving care has a need for skilled care that cannot be provided by unlicensed personnel (e.g., patients on a ventilator, patients requiring nasogastric or gastrostomy feedings, suctioning, etc.);
- No other individual in the recipient's support system is able to provide the skilled component of the recipient's care during the caregiver's absence; and
- The recipient is unable to receive skilled nursing visits from any other source, including home health, which could provide the skilled care usually given by the caregiver.

Under respite care services, a LPN can perform selected nursing procedures under the direction and supervision of a RN. Such selected procedures may include:

- Administration of medications;
- Care of tracheostomies, feeding tubes, etc.; and
- Wound care requiring sterile technique.

When a nurse is required, the nurse must also provide services normally provided by an aide. The nurse is required to document the tasks performed on the Skilled Respite Record (DMAS-90A). These records are to be kept in the recipient's respite record. For skilled respite services, the nurse's skills and knowledge necessary to provide the services must be documented.

If the recipient receives skilled respite services, a separate file or a separate section of the recipient's file must contain the forms, records, and necessary documents addressing respite services and authorization. These include:

- Skilled Respite Record (DMAS-90A), signed and dated by the nurse and the recipient or family/caregiver. It must contain weekly notes on the recipient's care and status;
- Respite Care Needs Assessment and Plan of Care (DMAS-300), if respite is the sole service the recipient is receiving;
- The RN Supervisor's documentation using the DMAS-99; and
- A physician's order for skilled services. The order must specify the skilled services that the nurse will render.

When respite is the sole service, the RN Supervisor must conduct the initial visit with the respite care aide immediately preceding the start of care and must conduct a supervisory visit according to the frequency established with the recipient.

If the respite care as a sole service is for a very short period of time (i.e., a weekend), the RN Supervisor must conduct the initial visit with the respite care aide or nurse, if receiving skilled respite, immediately preceding the start of care and make a telephone call to the aide during the period of respite care for the second visit. This telephone conversation must be clearly documented in the recipient's record. If the recipient is currently receiving personal care services and they are going to continue during the respite care period, the RN Supervisor does not have to make a second visit during the respite care period regardless of the length of the period. A follow-up telephone call to the primary caregiver should be made following the respite period.

Required Documentation For Recipient Records For Personal And Respite Care

Agency-Directed (AD) Model

The provider shall maintain a record for each recipient. These records must be separated from those of other services, such as companion services or home health. If a recipient receives personal care and respite care services, one record may be maintained, but separate sections should be reserved for the documentation of the two services. The following information may be reviewed during the Utilization Review (UR) process:

- The Pre-Admission Screening Uniform Assessment Instrument (UAI); the Pre-Admission Screening Authorization signed by all members of the PAS Team (DMAS-96); the Screening Team Plan of Care (DMAS-97 or DMAS-300 for Respite Care services); DMAS-101 (for all recipients with a diagnosis of MI or MR); all provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; and all Patient

Information Forms (DMAS-122). The DMAS-122 process must be coordinated with all service providers;

- The initial assessment by the RN Supervisor nurse must be completed on or before the start of care on the DMAS-99. This must be filed in the recipient's record within two weeks from the date of the visit. (See Chapter IV for the content of the initial assessment.) Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form, or OASIS form, is not acceptable;

- All RN Supervisor notes as documented on the DMAS-99 and must be completed and on file within two weeks of the date of the supervisory visit. Nursing notes must be in the recipient's record within two weeks of the last supervisory visit made to the recipient. Any supervisory visit not documented and present in the recipient's record will be considered as not having been made;

- Nursing notes must reflect all significant contacts with the recipient. It must be documented that the RN has made a supervisory visit (with the aide present at least every other visit) in the recipient's home;

- The frequency of the RN Supervisor visit must be conducted within the timeframe that was agreed upon by the recipient and/or caregiver and documented by the RN on the DMAS-99. If the recipient has a severe cognitive impairment (as previously defined in this chapter), the frequency of the supervisory visit must be at least every 30 days (not monthly). The RN, based on the above policy, has the final authority in determining the frequency of the supervisory visits;

- The RN Supervisor's documentation, using the DMAS-99, must include the observations of the recipient made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the recipient. The RN Supervisor's notes must also clearly document that he/she has discussed with the recipient or family member the appropriateness and adequacy of service. The RN must also note the presence or absence of the aide in the home during the supervisor's visit. Client/family/caregiver satisfaction with the services should be documented as well as all requirements for the RN Supervisor and documentation found in Chapter II of this manual;

- All provider contacts with the recipient, family members/caregivers, health professionals, formal and informal service providers, the pre-authorization contractor, DMAS, etc. All notes must be filed in the recipient's records within two weeks. Correction fluid must not be used to make corrections to the file. Any corrections made to the recipient's record must be initialed and dated;

- Provider Aide Records (DMAS-90) for services rendered and the recipient's responses. The DMAS-90 must be thoroughly completed. The DMAS-90 must document complete dates, the care given, and the times of arrival to and departure from the recipient's home each day the aide renders service. The records must be signed weekly by the aide, and

the recipient/caregiver. In instances where the recipient is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. The aides' weekly comments should note significant physical, social, and emotional aspects of the recipient's life that week. Signatures, times, and dates shall not be placed in the record prior to the date that the services are delivered. The aide record sheets must be in the recipient's record within two (2) weeks;

- The staff's personnel files must verify that the minimum qualifications outlined in Chapter II are met;

- Personal/respite services must have an individualized Plan of Care that reflects the results of an assessment completed prior to or on the date services are initiated (and subsequent reassessments annually and as needed) and includes the activities that will be provided during the personal care/respite care period and the approximate hours that will be allowed for each activity. The Provider Agency Plan of Care Form (DMAS-97A/B in "Exhibits" at the end of this chapter) may be used for this purpose;

- The appropriate Pre-authorization Request Form (DMAS-98) must be completed and submitted with the Plan of Care for authorization by the pre-authorization contractor to occur (see "Exhibits" section at the end of this chapter for sample forms);

- All correspondence with the individual, family/caregiver, DMAS, and the pre-authorization contractor;

- Significant contacts made with the family/caregiver, physicians, formal and informal service providers, and all professionals concerning the recipient;

- The supervisor must document in a summary note following significant contacts with the personal care aide and during supervisory visits to the recipient's home:

    a. Whether services continue to be appropriate;

    b. Whether the service is adequate to meet the recipient's needs or changes are needed in the plan;

    c. Any special tasks performed by the aide (e.g., assistance with bowel/bladder programs, ROM exercises, etc. See "Exhibits" for more details) and the aide's training/qualifications to perform these tasks;

    d. The recipient's or family's/caregiver's satisfaction with the service;

    e. Any hospitalization or change in medical condition or functioning status;

    f. Other services received and the amount; and

g. The presence or absence of the personal care aide in the home during the RN Supervisor's visit.

Documentation indicating the dates and times of respite services and the amount and type of service provided must be in the recipient's record. The DMAS-90 may be used for this purpose (see "Exhibits" section at the end of this chapter). The recipient's record must contain:

i. The specific services delivered to the recipient by the personal care aide and the recipient's response;

ii. The arrival and departure time of the aide, or recipient if going out of the home, for respite services;

iii. Comments or observations recorded about the recipient. Aide comments must include, at a minimum, observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered;

iv. The signature of the aide and the recipient or caregiver for each event to verify that services have been rendered; and

v. Signature, time, and dates shall not be placed in the record prior to the date that the services are delivered.

The provider is responsible for monitoring the ongoing provision of services to each Medicaid recipient. This monitoring includes:

- The quality of care provided by the aide and the RN;
- The functional and medical needs of the recipient and any modification necessary to the Plan of Care due to a change in these needs; and
- The recipient's need for support in addition to care provided, by personal/respite assistance. This includes an overall assessment of the recipient's safety and welfare in the home with personal/respite care.

RN Responsibilities/Required Documentation for Agency-Directed (AD) Personal Care Services

1. Supervisory Visits: The RN Supervisor must make supervisory visits as often as needed, but no fewer visits than provided as follows, to ensure both quality and appropriateness of services.

The minimum frequency of these visits is every 30 days for recipients with a cognitive impairment, and up to 90 days for recipients who do not have a cognitive impairment.

NOTE: If the RN is unable to conduct the supervisory visit because the recipient is hospitalized or out of town, the RN Supervisor visit is due by the third calendar day after the resumption of personal care services. For example, the RN Supervisor visit was made on January 1 with the next visit due no later than January 31. The recipient is hospitalized from January 27 through February 5, and the aide's services resume February 6. The RN Supervisor visit for the 30-day period (January 1 through January 31) had not occurred prior to the recipient's hospitalization. Therefore, a RN Supervisor visit is due on or before February 9, within three days of the resumption of care.

For recipients with a severe cognitive impairment, and up to every 90 days for recipients who do not have a severe cognitive impairment, as defined below:

Severe cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem solving, judgment, memory, or comprehension and interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

The initial home assessment visit by the RN shall be conducted to create the Plan of Care and assess the recipient's needs. The RN shall return for a follow-up visit within 30 days after the initial visit to assess the recipient's needs and make a final determination that the recipient does not have a severe cognitive impairment. This determination must be documented in the recipient's record by the RN. Recipients who are determined to have a severe cognitive impairment will continue to have supervisory visits every 30 days.

If the recipient does not have a severe cognitive impairment, as defined above, the RN may give the recipient or caregiver, or both, the option of having the supervisory visit every 60 days or any increment in between, not to exceed 90 days. The RN must document in the recipient's record this conversation and the option that was chosen. The RN has the final authority in determining the frequency of the supervisory visits.

The provider agency has the responsibility of determining if 30-day supervisory visits are appropriate for the recipient. The provider agency may offer the extended supervisory visits up to, but not to exceed 90 days, or the agency may choose to continue with 30-day supervisory visits based on the needs of the recipient. The frequency of the supervisory visits that is agreed upon by the RN Supervisor and the recipient and/or caregiver will be documented and entered in the recipient's record on the DMAS-99.

If a recipient's personal care aide is supervised by the provider's RN nurse less often than every 30 days and DMAS determines that the recipient's health, safety, and/or welfare is in jeopardy, DMAS may require the RN Supervisor to supervise the personal care aide every 30 days or more frequently than what has been determined by the nurse. This will be documented and entered in the recipient's record.

The personal/respite care provider must use the DMAS-99 to document the findings of these visits. The RN Supervisor must completely assess the recipient during each supervisory visit and document all the elements noted on the DMAS-99. The aide must be present during the RN Supervisor's visit at least every other visit. If the aide is always present during the RN Supervisor visit, then every other month the RN must make a telephone call to the family or recipient during non-personal care hours to assess the family and recipient's satisfaction with services. This telephone conversation must be documented in the recipient's record. This gives the family or the recipient, or both, the ability to address any concerns or issues without the presence of the aide.

Documentation must comply with DMAS requirements. The provider agency may use whatever additional documentation it feels necessary.

The RN Supervisor summary must note:

- Any change in the previously documented recipient's medical condition, functional status, and social support. The RN Supervisor is expected to know the nursing facility criteria found in the "Exhibits" section at the end of this chapter and to apply the criteria when assessing whether the recipient continues to meet nursing facility criteria to receive personal/respite care services. If the RN Supervisor determines that the recipient does not meet criteria for personal/respite care services, the RN Supervisor must contact the pre-authorization contractor to discuss discontinuation;

- Whether the Plan of Care is adequate to meet the recipient's needs or if changes need to be made;

- Dates of any lapse of services and why (e.g., hospitalization admission and discharge dates, aide not available, etc.);

- The presence or absence of the aide in the home during the visit; and

- Any other services received by the recipient.

In addition to the routine information, which must be documented in the RN Supervisor's summary, there are several areas that require special documentation during every routine supervisory visit by the RN Supervisor. These areas were addressed earlier in this chapter and are outlined below:

Supervision – The identification and need for supervision as a part of a recipient's Plan of Care must be pre-authorized by the PAS Team during the screening process. If the PAS Team identifies supervision as a needed service (on the DMAS-97 form), and the RN Supervisor identifies it as a needed service on the Plan of Care, the RN Supervisor may include supervision with authorization up to the maximum amount of hours for that level of care. If the addition of supervision hours will extend beyond the level-of-care cap, the RN Supervisor must contact the pre-authorization contractor for pre-authorization to include this in the Plan of Care. If supervision is not authorized on the DMAS-97, then during the initial assessment, the RN Supervisor determines there is a need for it, then the RN Supervisor must obtain authorization from the pre-authorization contractor prior to implementation.

In instances when supervision time is incorporated into the Plan of Care, and the total number of hours exceeds the number of hours allowed for the recipient's level of care, the RN Supervisor must contact the pre-authorization contractor to discuss the hours, services needed, and to obtain prior authorization for the hours above the level of care (LOC). The effective date for authorization for supervision hours will be given at the time of approval. DMAS will not reimburse retroactively for hours over the LOC, which were provided prior to the pre-authorization contractor's authorization date.

In every case in which the RN Supervisor has identified the need for supervision to be included in the recipient's Plan of Care, the following documentation requirements must be met:

The RN Supervisor must complete a DMAS-100 (Request for Supervision Form). This form must include the reason supervision is needed, the amount of supervision needed, and that the ability of all other support persons to provide supervision has been explored, and must identify who will provide supervision in the absence of the personal care aide;

- The RN Supervisor must document on the recipient's record his or her contact with the analyst at the pre-authorization contractor. (It is imperative that these notes include the date and time of the call, the name of the analyst to whom he or she spoke, and the final decisions and effective date for the hours requested.);

- A copy of the approval letter must be maintained in the recipient's file; and

- Under no circumstances may the time allotted for supervision on the Plan of Care exceed eight (8) hours in a day.

Bowel Program - A written physician's order in the recipient's file must specify the method and type of digital stimulation and frequency of administration. A new physician's order must be obtained every six (6) months or more frequently if

changes in the recipient's condition occur. The RN Supervisor must document that (i) the aide has received special training in bowel program management, (ii) the aide has knowledge of the circumstances that require immediate reporting to the RN Supervisor and contraindications as to when the aide cannot administer the bowel program (e.g. cardiac, dysreflexia, diarrhea, etc.), and (iii) the RN Supervisor has observed the aide performing this function. No manual disimpaction by the aide is permitted. Changing colostomy bags or emptying bags is permissible with RN Supervisor instruction and return demonstration. Fleet enemas may be administered with a physician's order and RN supervision. The aide's continued understanding and ability to perform bowel programs must also be observed and documented in the nursing note at least every 90 days.

Range-of-Motion (ROM) Exercises - The written physician order that indicates the need and extent of ROM exercises, which are to be performed, must be in the recipient's file. A new physician's order must be obtained every six (6) months or more frequently if changes in the recipient's condition occur. The RN Supervisor must document in the recipient record that the aide has been instructed by the RN Supervisor in the administration of ROM exercises and that the aide's correct performance of these exercises has been observed and documented by the RN Supervisor. The continued need for ROM exercises and the monitoring of the aide's performance of these exercises must be noted in the nursing note at least every 90 days.

Routine Wound Care - Each month, the RN Supervisor must document the status of the wound and the monitoring of the aide's care. There must be a specific physician's order in the recipient's record, and a new order must be obtained at least every six (6) months or more frequently if changes in the recipient's condition occur.

Catheter Care - When routine care of a urinary catheter is to be provided by the personal care aide, the RN Supervisor must indicate in the initial RN Supervisor note that the aide is providing catheter care and what instructions the aide has received from the RN Supervisor regarding this care. For condom catheters, the RN Supervisor must observe the initial application of the condom catheter and documentation must indicate the aide's ability to perform this procedure. The same procedure must be followed when substitute aides provide condom catheter care.

The RN Supervisor must note and follow-up on any concerns related by the recipient, family, or primary caregiver, aide, or other involved professional. Any time the permanently assigned aide changes, the recipient must be notified and it should be documented in the recipient's record. Recipient notification can be done by a RN Supervisor or other staff and can be done by telephone.

The RN Supervisor is responsible for taking appropriate action to ensure continued appropriate and adequate service to all recipients. Appropriate actions may include: counseling an aide about the care to be provided to the recipient, requesting from the pre-authorization contractor an

increase to the recipient's Plan of Care to include supervision, discussing with the recipient's family the need for additional care for the recipient, decreasing hours as appropriate, or contacting DMAS to request a special review of the recipient's case. Any time the provider is unsure of the action that needs to be taken, the provider should contact a DMAS review analyst in the Waiver Services Unit for consultation.

Aide Responsibilities/Required Documentation: Agency-Directed (AD) Model

The aide is responsible for following the Plan of Care, notifying the RN Supervisor of any change in condition, support, or problem that arises and documenting the performance of duties on the DMAS-90. The aide must document on the DMAS-90 the specific services delivered to the recipient and the recipient's response. The DMAS-90 must also contain the daily arrival and departure times of the aide. The aide must record comments or observations about the recipient on a weekly basis. Aide comments should include observation of the recipient's physical and emotional condition, daily activities, and the recipients response to services rendered. The aide and the recipient must sign the DMAS-90 once each week to verify that personal care services have been rendered. Documentation on the DMAS-90 must be in the English language. Signature, times, and dates must not be placed on the DMAS-90 prior to the last day of the week that the services are delivered. If the recipient is unable to sign the DMAS-90, a family member or friend may sign. If no other person is able to sign the DMAS-90, the recipient may make an "X". If the recipient is unable to sign or make an "X", the RN Supervisor must document on the DMAS-99 that the "recipient is unable to sign" the DMAS-90.

The DMAS-90 must be completed on a daily basis on the day the service was delivered. The DMAS-90 is designed to contain one calendar week of service provision and should be utilized in this manner. Agencies may not, in any way, make changes to the DMAS-90 to suit an individual provider's needs. If the same aide renders personal care and respite care services to the recipient, a separate DMAS-90 must be used for the different services, even if the two services are rendered on the same day.

Any corrections needed to the DMAS-90 should be made by drawing a line through the incorrect entry, then re-enter and initial the correct information. Correction fluids must never be used for correction. Copies of all DMAS-90s are subject to review by state and federal Medicaid representatives. The records contained in the chart must be current within two weeks at all times. It is the responsibility of the provider to ensure that the DMAS-90 are delivered to the provider and filed in the recipient's record within two (2) weeks. A periodic review of the DMAS-90 must be done prior to filing it in the recipient's record to ensure that the RN Supervisor is aware of any changes in the recipient's needs or any changes in the Plan of Care, which may be indicated by the aide's documentation on the DMAS-90. An accurately signed and dated DMAS-90 is the only authorized documentation of services provided for which DMAS will reimburse. DMAS will not accept employee payroll time sheets in place of the DMAS-90.

In addition to the RN and aide documentation, at a minimum, the recipient's record must contain the Uniform Assessment Instrument (UAI), the Pre-Admission Screening Authorization (DMAS-

96), the Screening Team Plan of Care (DMAS-97), the provider Plan of Care (DMAS-97A/B), DMAS-100 (if applicable), DMAS-101 (if applicable), and other DMAS and/or CMS forms that are applicable to the healthcare of the individual and authorization of services. Copies of these forms are in "Exhibits" at the end of this chapter.

Aide Responsibilities/Required Documentation: Consumer-Directed (CD) Model

Documentation must clearly indicate the dates and times of CD personal care services delivery (i.e., time sheets).

If nurse delegation is provided by the service facilitation provider, the nurse's documentation of training, supervising, and all other related information and documentation must be maintained by the service facilitation provider.

Required CD Services Facilitation Documentation

The CDSF must maintain records for each recipient served. At a minimum, these records must contain:

1. All copies of the CD services Plans of Care on the DMAS-97 A/B, the results of the CDSF's initial comprehensive home visit (and subsequent reassessment visits, as needed) on the DMAS-99, and the types of assistance (allowable activities) that will be provided during the Plan of Care period and the approximate hours. The start date on the Plan of Care will be the start date of service facilitation services for the recipient. If at the annual review, a new Plan of Care is not required (i.e., no change in level of service), the CDSF must still ensure that the pre-authorization contractor receives a copy of the revised Plan of Care prior to its due date. Failure to do so could jeopardize the CDSF's ability to bill for services or DMAS Participation Agreement;

2. The appropriate Pre-Authorization Request Form, completed by the CD Service Facilitator for authorization by the pre-authorization contractor (see the "Exhibits" section at the end of this chapter for sample forms);

3. All DMAS-122 forms [Note: If CD services are the only services a recipient is receiving and that recipient is assigned a patient pay, the patient pay amount is to be deducted from the aide's Medicaid reimbursement and the recipient is responsible for paying the patient pay amount directly to the aide.] The CDSF must send the DMAS-122 to the CD Fiscal Agent via fax or mail. This must be coordinated with all service providers;

4. CDSF notes recorded and dated documenting any contacts with the recipient and family member/caregiver as applicable and visits to the recipient's home;

5. All correspondence to the recipient and family member/caregiver, DMAS, and the pre-authorization contractor;

6. Updates to information about the recipient made during the provision of services;

7. Records of contacts made with family/caregiver, physicians, DMAS, formal and informal service providers and all professionals concerning the recipient;

8. All training provided to the aide on behalf of the recipient or family member/caregiver;

9. All management training provided to the recipient or family member/caregiver, including the recipient's or family member's/caregiver's responsibility for the accuracy of the aide's time sheets;

10. All documents signed by the recipient or the family member/caregiver that acknowledge the responsibilities for receipt of the services; and

11. The CD Service Facilitator must review the CD personal care Plan of Care and this review must be done every six months or when modified, as appropriate. For the annual review and in cases where the Plan of Care is modified, the Plan of Care must be reviewed with the recipient or family/caregiver. Documentation must include any revisions to the Plan of Care and also address the general status of the recipient, significant events, and recipient's or family member's/caregiver's, or both, satisfaction with services. The due date for the review is determined by the effective start date of the Plan of Care from the initial comprehensive visit.

However, the CD Service Facilitator must review the utilization of or dissatisfaction with CD services (recipient or family member/caregiver satisfaction) and CD respite either every six (6) months or upon the use of 300 respite hours, whichever comes first.

All criteria and documentation requirements must be met for the entire time the service is provided in order to be reimbursed under the EDCD Waiver. The CDSF will not be reimbursed for services unless the recipient is authorized for waiver services by the pre-authorization contractor.

TRANSPORTATION

Transportation is not a covered service through this waiver. Transportation to providers of Medicaid services can be arranged through the DMAS transportation broker. There are times that the aides or nurse may accompany the waiver recipient to medical appointments or to other activities. That process is described below. In no case will DMAS pay, through the EDCD Waiver, for mileage or other costs associated with transportation.

Transportation: Agency-Directed (AD) Services

Personal care aides or nurses (for skilled respite services) may accompany the waiver recipient to appointments or other activities based on the following criteria:

- The agency will not be reimbursed for time beyond the already approved Plan of Care hours, or for vacations or overnight trips;
- The aide/nurse is essential for the safe transport of the recipient (to assist in transfers, ambulation, behavior management, etc.);
- No other individual is available and physically able to accompany the recipient;
- The total time required by the aide/nurse for the day, including the time required to accompany the recipient, does not cause the recipient's weekly authorized hours to be exceeded. However, in some instances, due to events beyond the provider's control, the number of hours may be exceeded. In these cases, the provider must contact the pre-authorization contractor the next business day with the actual hours used for authorization of hours exceeded in the previous day's visit. It must be documented in the record why the hours were exceeded or the additional time may be deducted from another day as long as this does not jeopardize the recipient's health and safety. The RN Supervisor must be notified in advance of the appointment, and must document (with the date) this approval in the RN notes in the recipient's record;
- When the aide/nurse is required to accompany the recipient based on the above criteria, DMAS will pay the agency for the time the aide/nurse is accompanying the recipient to such appointments. This must be documented on the aide's/nurse's record; and
- DMAS will not pay the provider when the recipient is accompanied by the provider staff to the hospital or essential medical appointments when the recipient is being transported by ambulance.

Transportation: Consumer-Directed (CD) Services

As the aide is the employee of the recipient receiving CD services, any arrangements for transportation not paid for by the Medicaid program are between the aide and the recipient. This includes transportation necessary to implement the CD services Plan of Care (for example, to permit community access and activities). Thus, it is permissible for the aide to transport the recipient in the aide's, the recipient's, or the caregiver's vehicle.

The recipient or family member/caregiver must determine if the aide has a valid Virginia driver's license, is registered in the Commonwealth of Virginia, and has vehicle insurance that covers the following. Proof of the insurance coverage should be maintained in the recipient's file.

The insurance should insure the insured or the other person:

- Against loss from any liability imposed by law for damages;
- Against damages for care and loss of services, because of bodily injury to or death of any person;
- Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth of Virginia, any other state in the United States, or Canada;
- Subject to a limit exclusive of interest and costs, with respect to each motor vehicle of $25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of $50,000 because of bodily injury to or death of two or more persons in any one accident; and
- Subject to a limit of $20,000 because of injury to or destruction of property of others in any one accident.

The total time required by the personal care aide for the day, including the time required to drive the recipient, cannot exceed the recipient's authorized weekly hours. If the total time required exceeds daily hours, additional time may be deducted from another day as long as this does not jeopardize the recipient's health and safety.

ADULT DAY HEALTH CARE (ADHC) SERVICES – AGENCY-DIRECTED (AD) ONLY

Service Definition

Adult Day Health Care Services (ADHC) in Virginia may be offered to elderly individuals and individuals with physical disabilities who have been assessed to be at risk of institutionalization, meet the criteria for nursing facility care, and have been screened by a PAS Team for ADHC services and authorized for services by the pre-authorization contractor review analysts. ADHC services are defined as long-term maintenance or supportive services which are necessary in order to enable the recipient to remain at home rather than enter a nursing facility. ADHC can be offered only to recipients meeting PAS criteria (the same long-term care criteria as required for personal care and respite care admission) and for whom ADHC (either solely or in conjunction with personal care, respite care, and/or PERS) would be an appropriate alternative to institutional care.

ADHC services are designed to prevent institutionalization by providing recipients with health, maintenance, and rehabilitation services in a congregate daytime setting. The significant difference between ADHC and personal care is the congregate setting in which ADHC is rendered. DMAS will enter into Participation Agreements with qualified adult day care centers which are licensed by the Virginia DSS and which meet all DMAS provider standards to provide ADHC services to Medicaid-eligible recipients who have been authorized to receive ADHC.

Activities

The services offered by the ADHC Center must be designed to meet the needs of the individual recipient. Thus, the range of services provided by the ADHC Center to each recipient may vary to some degree. There must, however, be a minimum range of services available to every Medicaid ADHC recipient: nursing services, rehabilitation services coordination, transportation, nutrition, social services, recreation, and socialization services.

DMAS will reimburse a per-diem fee to any approved ADHC Center that has a Participation Agreement with DMAS (see Chapter V). This is considered payment in full for all services rendered to that recipient as a part of the recipient's approved ADHC Plan of Care. A day is defined as attendance at the ADHC Center for six hours or more.

Aide Responsibilities: The aide must provide assistance with activities of daily living (e.g., ambulating, transferring, toileting, eating or feeding, bathing, dressing), supervision of the recipient, and assistance with the management of the recipient's Plan of Care.

Nursing Responsibilities: These services include periodic evaluation of the nursing needs of each recipient; provision of the indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervising the recipient in self-administered medication; or general supervision of individuals who are certified in medication management and administering medications through the Board of Nursing.

Nursing functions also include the support of families in their home care efforts through education and counseling, and helping families identify and appropriately utilize health care resources.

Rehabilitation Services Coordination Responsibilities: These services are designed to ensure the recipient receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech therapy. The ADHC Center may arrange for individual rehabilitation treatment with an outpatient facility or independent rehabilitation provider. The coordination and implementation responsibilities of the ADHC Center include:

- A referral for an evaluation by the appropriate rehabilitative discipline when necessary;
- Provision of rehabilitation therapy in the ADHC Center if the recipient chooses to receive rehabilitation services during ADHC. Reimbursement for rehabilitation services are not part of the reimbursement fee for ADHC; and
- Coordination of any resultant rehabilitative treatment plan into the recipient's overall Plan of Care to include arrangement of transportation from the ADHC Center to the rehabilitation provider if necessary, and implementation by ADHC

staff (designated by the Coordinator) of activities prescribed by the therapist in conjunction with ongoing therapy.

Transportation Responsibilities: Every DMAS-approved ADHC Center must provide transportation when needed in emergency situations for any Medicaid recipient to and from his or her home (e.g., the primary caregiver has an accident and cannot transport the recipient home). Any ADHC Center which is able to provide recipients with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip (to and from the recipient's residence) fee (see Chapter V).

Nutrition Responsibilities: The ADHC Center must provide one meal per day, which supplies one-third of the daily nutritional requirements. Special diets and counseling must be provided as necessary.

ADHC Coordination: The ADHC Coordinator, designated by the ADHC Director, must coordinate the implementation of the Plan of Care, make updates to the Plan of Care, record 30-day progress notes, and review the recipient's daily log each week (when the log is completed by a program aide). The designation of a professional staff member as the ADHC Coordinator is intended to promote the maintenance of the recipient's physical and mental health by coordinating services and providing assistance with any personal or social problems. This may be accomplished by individual or group discussion of problems, coordination with family, home, and other community agencies, counseling and referral to available community resources. In cases where the recipient only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

Recreation and Social Activities Responsibilities: The ADHC Center must provide planned recreational and social activities suited to the needs of the recipients and designed to encourage physical exercise, prevent deterioration, and stimulate social interaction.

A multi-disciplinary approach to developing, implementing, and evaluating each recipient's Plan of Care is essential to quality ADHC services.

Skilled Services and ADHC

An ADHC Center may choose to admit recipients who have skilled needs. Examples of the type of services requiring professional skills include the following: tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique. ADHC Center aides cannot perform these services. It is permissible, however, for a nurse to give skilled services at the same time that an ADHC aide is in attendance. An ADHC center can admit recipients who have skilled needs only if there is professional nursing staff immediately available on-site to provide for the specialized nursing care required by these recipients.

ADHC services may take the place of personal care services either completely or for several days a week if it is determined that this would meet the needs of the recipient. ADHC augments the social support system available to the recipient by providing some assistance with activities

of daily living. A recipient may attend ADHC during the day and also receive personal care services in the morning or evening, or both, as appropriate to meet the identified needs.

Re-Evaluation of the Adult Day Health Care (ADHC) Recipient

The ADHC Center professional staff will continually assess the adequacy of ADHC services for each recipient and shall meet and document changes in the recipient's condition and Plan of Care at least every three months.

Whenever the professional staff determines that ADHC services, either alone or in combination with other community resources, are no longer appropriate for a recipient, the ADHC Center will contact a review analyst at the pre-authorization contractor. The review analyst will conduct a re-evaluation of the recipient's needs to ensure that the recipient is receiving services which meet his or her needs and ensure the recipient's continued health and safety in the community in a cost-effective health care setting.

DMAS will conduct annual level-of-care reviews of each recipient according to established procedures described in Chapter VI.

Inability to Provide ADHC Services

The provider is responsible for providing reliable, continuous care to any Medicaid ADHC recipient for the number of hours per day or days per week as outlined on the Plan of Care. Any time the provider is unable to furnish ADHC services as determined in the Plan of Care, the recipient or recipient's family must be notified immediately, and documentation of the contact recorded in the recipient file. An ADHC provider may sub-contract with another ADHC provider if they cannot provide the number of days per week as written in the Plan of Care.

The provider should explore with the recipient, prior to the start of services, his or her back-up plan or ability to go without service (in the event the provider cannot provide ADHC services). Back-up support can be provided by an informal network of friends or neighbors who can be called on as needed as long as this ensures the recipient's needs are met.

In addition to the above, all ADHC providers enrolled in the Virginia Medicaid Program must adhere to the conditions outlined in their individual Participation Agreements.

Service Units and Limitations

ADHC services cannot be offered to recipients who are residents of intermediate care facilities, skilled care facilities, assisted living facilities, or adult foster homes licensed or certified by DSS.

Provider Documentation Requirements

The ADHC Center shall maintain all records of each ADHC recipient. These records shall be reviewed periodically by the DMAS staff. At a minimum, these records shall contain:

- The Uniform Assessment Instrument (UAI), the Pre-Admission Screening Authorization (DMAS-96), the Screening Team Plan of Care (DMAS-97), and the DMAS-101 (if applicable). Copies of these forms are in "Exhibits" at the end of this chapter;

- The Interdisciplinary Plan of Care (DMAS 301) developed by ADHC Center professional staff. A copy of the ADHC Interdisciplinary Plan of Care is in "Exhibits" at the end of this chapter;

- At least every three months at an interdisciplinary staff meeting, the Plan of Care must be reviewed and updated. The initial ADHC Plan of Care can be used for documentation of interdisciplinary staff meetings and to make up to three updates to the Plan of Care as long as the recipient's status has not significantly changed. A new Plan of Care should be developed whenever re-evaluation indicates a need for significant changes to the Plan of Care;

- At a minimum, the individual designated as the ADHC Coordinator should record 30-day progress notes. If a recipient's condition and Plan of Care change more often, progress notes must be written more often than every 30 days. Progress notes must:

    1. Describe the recipient's medical and functional status;

    2. Note contacts made to or from the primary caregiver;

    3. Indicate any change in social supports;

    4. Indicate any other services received by the recipient; and

    5. Reference a review of the 30-day rehabilitative progress report and updated Plan of Care, if appropriate.

    DMAS does not require a form for recording the progress notes. However, the DMAS-99 form may be used for this purpose. At a minimum, the functional status section of the DMAS-99 form must be completed every 30 days by the RN or ADHC Coordinator;

- The ADHC Center will obtain a rehabilitative progress report and updated treatment plan from any professional discipline involved in the recipient's care every 30 days (e.g., physical therapy, speech therapy, occupational therapy, etc.);

- Daily logs of service provided (DMAS-302) - The daily log must contain the specific services delivered by ADHC Center staff. The log must also contain the arrival and departure time of the recipient and a weekly signature by an ADHC professional staff member. The daily log must be completed on a daily basis, not before or after the date of service delivery. At least once a week, a staff member must chart significant comments regarding care given to the recipient. The weekly comment section must be completed unless that information is contained elsewhere in the recipient's record. If the staff member writing comments are different from the staff member signing the weekly log, the commenting staff member must sign the weekly comments. Rubber-stamped signatures cannot be used;

- All correspondence to the recipient and to the pre-authorization contractor; and

- All Plans of Care.

The provider must use the approved DMAS forms or exact duplicates, where indicated. These forms may be downloaded from the DMAS website or may be copied from the "Exhibits" sections in this manual.

AUTHORIZATION FOR RECIPIENTS ALREADY ATTENDING ADULT DAY HEALTH CARE (ADHC) AS PRIVATE PAY OR GRANT-FUNDED

Recipients who are currently attending an ADHC Center under a private pay or grant status, whose funding source has been exhausted, and who may be determined Medicaid-eligible, may be eligible for ADHC services under the EDCD Waiver. The ADHC Center should contact the local PAS Team and arrange for a screening to be completed on the recipient in question. The PAS Team determines the recipient's status as a recipient in need of Medicaid-funded ADHC services. A request for a Pre-Admission Screening for nursing facility placement can be initiated by the recipient who desires the requested care, a family member, a physician, a local health department or social services professional, or any other concerned individual in the community. ADHC services provided under the EDCD Waiver must be pre-authorized by the pre-authorization contractor, as outlined elsewhere in this chapter.

ADHC RESPONSE TO REFERRAL

The ADHC provider shall not begin services for which they expect Medicaid reimbursement until the admission packet is received from the PAS Team and not before the date authorized by the PAS Team on the DMAS-96. It is the responsibility of the provider to ensure that it receives a complete and correct screening packet prior to starting care.

The ADHC provider has the authority and responsibility to determine, prior to accepting the referral from the PAS Team, whether the provider can adequately provide services to the recipient. No referral should be accepted unless the provider has the staff capability and the recipient being referred appears appropriate for the provider's program. There may, however, be

instances where the provider is unaware of a problem that will prohibit service delivery until the ADHC completes the initial assessment.

Upon receipt of the referral and no later than the recipient's fifth (5th) visit to the ADHC Center, the Plan of Care must be developed based on the needs identified by the PAS Team and the ADHC professional staff's evaluation of the recipient's need for nursing, transportation, nutrition, social work, rehabilitative services, PERS, and recreation services. The staff will meet to develop a Plan of Care for that recipient, using the ADHC Interdisciplinary Plan of Care (DMAS-301) to document the goals and objectives for each of the major areas of recipient needs. The DMAS-301 must include the recipient's name and Medicaid number, the ADHC provider identification number, signatures of the interdisciplinary team members present, the date services actually began, and the content of the Plan of Care. The DMAS-301 must also address all medications the recipient takes, not just those received at the center.

If, during the development of the interdisciplinary Plan of Care, the ADHC Center evaluates the recipient's needs and develops a Plan of Care that involves a change to the number of days or hours of participation in ADHC from the days or hours authorized by the PAS Team, the ADHC Center must contact the pre-authorization contractor to discuss a possible change in Plan-of-Care authorization. The ADHC provider must contact the pre-authorization contractor for pre-authorization any time the number of days a recipient attends ADHC changes, including changes from the initial screening (DMAS-97) to the provider's start of services.

RESPONSE TO INAPPROPRIATE AUTHORIZATION OF ADHC SERVICES

The ADHC should not initiate services if the ADHC professional staff determines one of the following during the initial assessment:

- The recipient is not appropriate due to health, safety, and welfare concerns;
- An appropriate Plan of Care cannot be developed to meet the recipient's needs;
- The recipient does not meet the criteria for the program; or
- The recipient does not meet the target population for the EDCD Waiver.

If the ADHC determines that the ADHC should not initiate services, the ADHC must notify the PAS team of this decision immediately. The ADHC must send a letter of notification to the recipient informing them of this and provide appeal rights.

MONITORING THE RECIPIENT'S CONDITION AND CHANGES TO THE PLAN OF CARE FOR ADHC SERVICES

The ADHC provider must assess the recipient's functional and medical condition and record as necessary any changes to his or her condition in the 30-day progress notes and quarterly on the DMAS-301. The provider must know the DMAS criteria for ADHC services and take action to

modify the Plan of Care as needed to ensure that the days and type of care and services are appropriate to meet the current needs of the recipient. If the provider determines the recipient is no longer appropriate for attendance at the center, the provider may discharge the recipient from their center, but not from authorization for the waiver. It is the responsibility of the provider to notify the pre-authorization contractor and DMAS when the provider believes the recipient no longer qualifies for services under the waiver. Only DMAS may terminate the recipient from the waiver. The provider should complete a Level-of-Care Review Instrument (DMAS-99C) and the Community-Based Care Request for Information Form (DMAS-98), known as the pre-authorization contractor fax cover sheet, and send it by either fax or mail to DMAS, Attention: Level-of-Care Reviews, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. If the provider has discharged the recipient from its services, the provider must also send the Patient Information Form (DMAS-122) with the last date of service to the level-of-care analyst at DMAS. The DMAS-122 must also be sent to the pre-authorization contractor and DSS to notify them of the recipient's discharge from the provider's services.

ADHC services may be authorized for up to seven (7) days of service and 14 trips per week based on the recipient's needs and the center's availability. Any time the number of days a recipient attends ADHC or the number of transportation trips provided by the center changes, the Plan of Care must be modified. The ADHC Coordinator must contact the pre-authorization contractor to ensure that the correct number of days is entered into the system to facilitate correct claims processing. The most recent Plan of Care must always be in the recipient's record.

CHANGE IN SERVICE PROCEDURES FOR ADHC

Increase in Days of Service

the pre-authorization contractor must pre-authorize any increase in days of service, either at the time of enrollment or afterward. The ADHC Center must contact the pre-authorization contractor and provide the following information:

- The reason the increase in days of service is needed;
- The effective date of the increase;
- The recipient's Medicaid number; and
- Information regarding the recipient's functional and medical status, social support system, and other services the recipient receives.

(Note: If the recipient receives personal care under the EDCD Waiver, the ADHC Center must have the provider number of the personal care provider and must know how personal care services will be affected by the increase in the days of service.)

If the pre-authorization contractor approves the increase, authorization will be given and an authorization letter will be sent to the ADHC provider. The ADHC will send a copy of this letter to the personal care provider (if applicable).

If the increase is denied, the pre-authorization contractor will indicate on the Community-Based Care Authorization Form that the increase was denied and the reason for the denial. the pre-authorization contractor will send this copy to the ADHC Center. the pre-authorization contractor staff will enter authorizations or denials in the computer. Once the entry has been made, the provider and recipient will receive a computer-generated letter from First Health Services notifying them of the decision and providing appeal rights if a denial is issued. Recipients have the right to appeal any adverse action taken by the pre-authorization contractor. A copy of this letter must be maintained in the recipient's record. If a denial is issued, the provider will also be notified by fax by the pre-authorization contractor. Recipients have the right to appeal any adverse action taken by the pre-authorization contractor.

The pre-authorization contractor will not retroactively approve increases.

Decrease in Days of Service (ADHC-Initiated Decrease)

- The ADHC Center will send the recipient a letter giving the reason for the decrease, the effective date of the decrease, the recipient's Medicaid number, and the recipient's right to appeal.

- A copy of this letter will be sent to the pre-authorization contractor.

The pre-authorization contractor staff will enter increases and decreases of service into the computer. Once the entry has been made, the provider should receive a computer-generated letter informing the provider that the change was made and that the provider may now bill for the change in service.

It is not necessary for the ADHC to send the pre-authorization contractor the revised Plan of Care or supporting documentation unless this information is requested. Plans of Care and the Community-Based Care Authorization Forms must be maintained in the recipient's record. The Plans of Care and documentation-of-service delivery must be consistent with the information communicated to the pre-authorization contractor.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Service Definition

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors recipient safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-

hour response or monitoring center upon activation and via the recipient's home telephone line. When appropriate, PERS may also include medication monitoring devices.

DMAS will only reimburse services as defined in the service description, documented in the individual's approved Plan of Care, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those recipients, ages 14 and older, who live alone, are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency and who would otherwise require extensive routine supervision. Recipients must be receiving PERS services and another EDCD Waiver service simultaneously. While medication monitoring services are also available to those receiving PERS services, medication monitoring units must be physician ordered and are not considered a stand-alone service.

If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependant in the category of "behavior patterns and orientation" on the Uniform Assessment Instrument. A recipient may not receive PERS if he/she has a severe cognitive impairment. Severe cognitive impairment means a severe deficit in mental capability that affects areas such as thought processes, problem solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

Service Units and Limitations

There is a one-time reimbursement for installation of the unit(s) per provider, which shall include installation, account activation, recipient and caregiver instruction, and removal of equipment. A unit of service for PERS monitoring is the one-month rental price set by DMAS. A unit of service for PERS nursing services for the purpose of refilling the medication monitoring device is one-half hour. The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line within seven (7) days of the request unless there is appropriate documentation of why this time frame could not be met.

PERS services shall be capable of being activated by a remote wireless device and be connected to the recipient's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device shall be waterproof, shall automatically transmit to the response center, activate a low-battery alert signal prior to the battery losing power, and be able to be worn by the recipient.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, a licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients. Direct marketing means (1) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (2) mailing directly; (3) paying "finder's fees;" (4) offering financial incentives, rewards, gifts, or special opportunities to eligible recipients as inducements to use their services; (5) continuous, periodic marketing activities to the same prospective recipient, e.g., monthly, quarterly, or annual give-aways, as inducements to use their services; or (6) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing recipients' use of provider's services.

Additional PERS Requirements

The PERS provider must properly install all PERS equipment into the recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

The PERS installation shall include local seize line circuitry, which guarantees the unit to have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

A PERS provider must maintain all installed PERS equipment in proper working order.

The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Standards for PERS Equipment

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

A PERS provider shall furnish education, data, and ongoing assistance to DMAS and/or the pre-authorization contractor to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and shall instruct the recipient, caregiver, and responders in the use of the PERS service.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the recipient's notification of a malfunction of the console unit, activating devices, or medication monitoring unit while the original equipment is being repaired.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home for a minimum period of 24 hours and automatically transmit a low-battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to assure that the monitoring agency and the provider's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from recipients' PERS equipment. The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- A back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- A back-up power supply;
- A separate telephone service;
- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

<u>Provider Documentation Requirements (Agency- and Consumer-Directed)</u>

1. The PERS Request Form (DMAS-100A), to be completed by the provider/CDSF, may serve as the Plan of Care, provided it adequately documents the need for the service, the type of device to be installed, and description of ongoing services, including training regarding the

use of the PERS. This pre-authorization form must be submitted to the pre-authorization contractor for authorization to occur (see "Exhibits") and maintained in the recipient's record;

2. A PERS provider must maintain a data record for each recipient utilizing PERS at no additional cost to DMAS. The record shall document all of the following:

   - Delivery date and installation date of the PERS;
   - Recipient/caregiver signature verifying receipt of PERS device;
   - The PERS device is operational as verified, minimally, by a monthly test;
   - Updated and current recipient responder and contact information, as provided by the recipient, CDSF, or the recipient's care provider; and
   - A case log documenting recipient system utilization and recipient, family/caregiver, provider, CDSF, or responder contacts/communications;

3. The PERS provider shall document and furnish, within 30 days of the action taken, a written report to the primary provider for each emergency signal, which results in action being taken on behalf of the recipient. This shall exclude test signals or activations made in error.

The PERS provider must document and furnish a written report for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or activations made in error. This written report must be furnished to the personal care provider/Service Facilitator, or in cases where the recipient only receives ADHC services, to the ADHC provider. This information must be maintained in the recipient's record at the PERS provider agency. The PERS provider must retain a copy of the DMAS-100A in the patient records.

PRE-AUTHORIZATION OF EDCD WAIVER SERVICES

Pre-authorization for EDCD Waiver enrollments is conducted by the pre-authorization contractor, the DMAS contractor. The pre-authorization contractor reviews all pre-authorization requests, including enrollments, re-enrollments, transfers, requests for additional services, and telephonic inquiries. Providers have the option of submitting all pre-authorization requests to the pre-authorization contractor either telephonically, via facsimile, or by mail. Initial enrollments must be faxed or mailed. Facsimile is preferred to provide for an efficient process and quick turnaround time. Any other requests may be received by telephone, fax, or mail. If necessary, the pre-authorization contractor will request additional documentation be submitted by fax or mail.

The PAS Team determining recipient eligibility for waiver services will call the provider first to notify the provider that the individual has chosen the provider for services and to determine if the provider is able to initiate services promptly for the recipient. Providers may accept referrals for

services only when staff is available to initiate services within two (2) weeks. If the provider can accept the referral, the PAS Team will send the provider a complete packet required for the provider to admit the recipient to services. A provider should not initiate any services prior to the receipt of the required screening and paperwork.

If the provider does not receive an entire, fully completed packet of referral forms, as noted below, from the PAS Team, the provider must notify the responsible PAS Team and request the completed packet. Accurate and complete packages will help reduce delays in enrollment and billing. Providers must have a complete screening packet for payment of services by DMAS.

To ensure timely authorization for reimbursement, enrollments and all requests for service authorization must be submitted to the pre-authorization contractor within ten (10) business days of the initiation of all services that need authorizations. Providers will not be eligible for reimbursement for services until the pre-authorization contractor receives and approves the packet of information completed by the PAS Team, along with the provider's Plan of Care showing the start-of-care date and the other necessary forms. If requests are not submitted within ten (10) business days, services may be authorized from the date the pre-authorization contractor receives all requested information. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided. In cases of retroactive eligibility, providers will have ten (10) business days from the date of notification of the recipient's eligibility on the DMAS-122 from the DSS to submit the request for authorization. If requests are not submitted within ten (10) business days of this notification, services may be authorized from the date the pre-authorization contractor receives all requested information. The provider must note the date that Medicaid eligibility was received from the DSS on the DMAS-98.

The earliest service authorization date is the date of the physician's signature on the DMAS-96. If the recipient has been receiving personal/respite care services and the provider requests the addition of ADHC, Medicaid will not pay for any ADHC services delivered prior to the authorization date on the the pre-authorization contractor authorization letter. The provider should have a Medicaid identification number for any authorized recipient prior to the start of Medicaid-funded services if the provider wants to be guaranteed payment for services provided.

The forms, which must be completed by the PAS Team and forwarded to the EDCD Waiver provider, are listed earlier in this chapter.

When the PAS Team authorizes combined services, it will send the original forms to the provider agency that the recipient requests to receive most of his/her services (i.e., agency-directed service provider, service facilitation, or the ADHC Center). If a recipient is authorized to receive one waiver service and later requests an additional waiver service, the new service provider must request authorization of service prior to initiating services. The two providers must coordinate to determine which waiver service has the most authorized number of hours per month. Since ADHC is authorized by the day, the center should calculate one day of authorization equals six (6) hours of authorized hours per day. For more information about patient pay, see Chapter IV's Patient Pay Amount section on page 6.

The pre-authorization contractor review analyst will need the following information to complete this authorization:

- The anticipated provider of personal/respite care/ADHC/PERS services (including the Medicaid provider identification number);
- The anticipated start date for personal/respite care/PERS services; and
- The estimated number of weekly hours, days, and times the personal/respite care/PERS is needed.

Addition of Personal/Respite Care as an Additional Service

If the recipient has been screened and approved to receive ADHC and the need for personal care has been identified after ADHC has been initiated, the ADHC or personal care provider must contact the pre-authorization contractor review analyst for authorization of personal care. ADHC would then become the program with responsibility. The pre-authorization contractor will conduct an assessment of the need for the additional Community-Based Care Service (personal or respite care), and, if appropriate, will authorize the additional service.

The pre-authorization contractor review analyst will need the following information to complete this authorization:

- The anticipated provider of personal/respite care services (including the Medicaid provider identification number);
- The anticipated start date for personal/respite care services; and
- The estimated number of hours and times the personal/respite care is needed.

When the need for episodic respite care as an additional EDCD Waiver service has been identified (according to the criteria above), the provider of the initial EDCD Waiver service or respite provider must contact the pre-authorization contractor. The pre-authorization contractor will conduct an assessment of the recipient's caregiver's need for respite care and, if appropriate, authorize respite care. It is at the discretion of the pre-authorization contractor's review analyst whether documentation will need to be submitted from the provider.

When the need for an additional EDCD Waiver service has been identified (according to the guidelines above), the provider of the additional EDCD Waiver service must complete a Plan of Care and contact the pre-authorization contractor for authorization. The pre-authorization contractor will review the information submitted and, if appropriate, authorize this additional service. It is at the discretion of the pre-authorization contractor's review analyst whether additional documentation is needed. In cases where PERS is the additional service identified, the initial provider should assist the recipient in obtaining this service.

The provider must submit to the pre-authorization contractor a copy of the Admission Package: the Uniform Assessment Instrument (UAI), the Pre-Admission Screening Authorization (DMAS-96), the Screening Team Plan of Care (DMAS-97) or DMAS-300 for Respite Care, the provider Plan of Care (DMAS-97A/B), the Adult Day Health Care Interdisciplinary Plan of Care (DMAS-301), the DMAS-101 for recipients with mental illness or mental retardation, the Nursing Assessment form which indicates the recipient's level of care (DMAS-99), and the Patient Information Form (DMAS-122) if the DMAS-122 is available at the time of submission of the admission package. The provider will retain the originals.

Authorization for respite care may be made by the pre-authorization contractor as a sole service, or may be added for a recipient already receiving personal care or ADHC services. When respite is added as an additional service, the pre-authorization contractor must be contacted for authorization of the addition of respite services.

A recipient's respite care year begins January 1 of each year through December 31 of the same year. The start-of-care date is entered into the computer for a one-year period; for example, from January 1, 2001-December 31, 2001, for 720 hours total. If the recipient did not request respite care until June 1, 2001, he would have 720 hours from June 1, 2001 through December 31, 2001. The provider must track the number of respite hours used during the year. The provider does not need to send to the pre-authorization contractor the number of hours used each time that respite is provided.

Providers are responsible for reviewing the recipient's Medicaid card or calling the toll-free eligibility verification number (1-800-884-9730) to confirm the recipient's Medicaid eligibility status prior to the start of care, or both. For any recipient identified in a QMB status, the provider should contact that recipient's eligibility worker at the local DSS prior to the start of care to receive assurance that the recipient's services will be covered.

Respite Care

Respite services of a personal care aide (agency or consumer directed) or services of a nurse (agency directed) that are specifically designed to provide temporary, substitute care that is normally provided by the family or other unpaid, live-in primary caregiver of an individual. Respite is for the relief of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual. These services are provided on a short-term basis because of the emergency absence, or need for routine or periodic relief, of the primary caregiver who lives in the home with the individual. In the situation when several caregivers take turns staying at night with the individual, respite care cannot be used because none of these individuals is the live-in primary caregiver. Respite services are provided in a Medicaid-certified nursing facility, the individual's home.

The maximum amount of respite care services that a recipient may receive is 720 hours in a calendar year. Individuals who are receiving consumer-directed, agency-directed, and facility-based respite services cannot exceed 720 hours per calendar year combined. For agency-directed

respite care, the personal care agency is responsible for tracking the number of hours used; for consumer-directed respite care, the service facilitator is responsible for tracking the number of hours used. If the individual is using both agency and consumer-directed respite services, the service facilitator and the personal care agency must coordinate the tracking of the respite care hours used. If more than 720 hours per year are provided, DMAS will pay for the first 720 hours provided per calendar year.

Recipients who exhaust their maximum amount of hours prior to the end of the authorization period must be informed that no additional hours will be authorized. In these cases, they must wait until the calendar year has expired.

A personal care aide usually provides respite care services. However, an LPN or an RN may provide respite in cases where the recipient has a skilled nursing need, provided there is a physician order for the services that will be provided. Respite care can be authorized as a sole community-based care service, or it can be offered in conjunction with other waiver services. Medicaid payment is available only for services authorized and provided according to the plan of care and provided by a qualified provider.

Addition of ADHC as an Additional Service

If a recipient has been screened and authorized to receive only personal/respite care and the need for ADHC as an additional home- and community-based care service has been identified, the personal/respite care or ADHC provider must contact a pre-authorization contractor review analyst to obtain authorization.

The pre-authorization contractor review analyst will need the following information to complete this authorization:

- The reason ADHC services are being sought;
- The ADHC Center the recipient will attend (including the center's Medicaid provider identification number);
- The start of care for attendance at the ADHC setting;
- The number of days per week a recipient will attend; and
- Whether transportation will be provided through the ADHC Center.

First Health Services will then send a copy of the computer-generated authorization letter to the requesting provider.

Telephonic Pre-Authorization

To initiate a telephonic request, providers call the pre-authorization contractor directly and provide the information requested by the analyst. While on the line, the analyst will approve, deny, or pend the request for additional information. Providers will know the status of the request before the call ends. All initial telephonic requests as well as any information submitted in response to pended letters must be directed to the pre-authorization contractor. Additionally, the provider will need to verify that the required documentation and justification exists in accordance with federal and state regulations and DMAS published criteria, policy, and procedures. Fully completed Plans of Care and appropriate justification of services will be verified upon DMAS post-payment review audit and may be requested by the pre-authorization contractor for pre-authorization determination. In addition to verbal confirmation of the decision, the pre-authorization contractor will send a written validation that will include a 9-digit tracking number. The pre-authorization contractor can be contacted at:

1-804-648-3159	Richmond
1-800-299-9864	All other areas

Providers have the option of mailing or faxing requests as well. If a request is made for adding services to an existing recipient who has an immediate need (immediate need as identified as within 1-3 days from the request date), the provider is encouraged to initiate telephonic pre-authorization. If the RN Supervisor assesses the need for supervision time or hours over the level of care on the initial visit of a new enrollee, the request for pre-authorization of supervision time should be made by telephone. The authorization may be approved. However, this is dependent on the recipient meeting criteria for the waiver. A tracking number will be assigned and given to the provider while on the line; this tracking number must be included with the submission of the new enrollment so that the authorization for supervision time will be included in the provider's pre-authorization request for the new enrollment.

Facsimile Pre-Authorization Requests

To submit a request by facsimile, all necessary documentation must be sent with the completed Community-Based Care Request for Services cover sheet, located at the end of this chapter under the "Exhibits" section.

Fax requests to the following numbers:

1-804-648-6992	All areas
1-866-510-7074	Toll-free

Mail Pre-Authorization Requests

All initial enrollments must be mailed or faxed. To submit information via mail, complete the Community-Based Care Request for Services cover sheet located at the end of this chapter under the "Exhibits" section. Mail requests to the following address:

WVMI
ATTN: CBC Review Unit
6802 Paragon Place
Suite 410
Richmond, Virginia 23230

Information in response to a pend must be submitted to the pre-authorization contractor within 14 business days. Failure to provide the requested information to the pre-authorization contractor will result in a rejection or denial of the request. If the request is rejected, an entirely new request must be submitted to the pre-authorization contractor within ten (10) business days of the initiation of services, as with all new requests.

Provider Reconsiderations and Appeals

If the pre-authorization contractor analyst denies authorization of services already rendered and the provider wants to request reconsideration of the denial, the provider must proceed with the following reconsideration process. If a telephonic request is denied, the provider may either request telephonic or written reconsideration from the pre-authorization contractor Pre-authorization Supervisor within 30 days of the date of the denial. The pre-authorization contractor Pre-authorization Supervisor has the option of requiring written reconsideration of a telephone pre-authorization request. If a written request is denied, the provider must submit a letter to the pre-authorization contractor Pre-authorization Supervisor requesting reconsideration within 30 days of the notice.

Upon completion of the reconsideration process, if the denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial of the reconsideration. All written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Recipient Appeals

The denial, reduction, or termination of services may be appealed in writing by the Medicaid recipient or his/her authorized representative within 30 days of the written notification of the denial. If the recipient requests an appeal before the effective date of the action, the provider may be required to continue the level and type of services that were being provided prior to the proposed change. A representative from DMAS will notify the provider if continued coverage must be provided. In this event, coverage must continue, unchanged, throughout the appeal process. All written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DISCONTINUE CHANGE IN SERVICES BY THE PROVIDER - ADVANCE NOTICE REQUIRED FOR PERSONAL/RESPITE/ADHC/PERS

There are various financial, social, and health factors that might cause a provider to discontinue, increase, or decrease services to a Medicaid recipient. The provider must make adjustments to services as indicated by any change in the recipient's needs or situation. The provider must give the recipient or family 10 days' written notification plus three days for mailing of any decision to discontinue or to change the amount of services received (unless the recipient requests a date which is less than ten (10) days and the provider documents the recipient's request).

Decrease in Hours

If the RN Supervisor has determined that a decrease in hours of service is warranted, the RN Supervisor must discuss the decrease in hours with the recipient or family during a home visit and document the visit and conversation in the recipient's record. If there is to be a decrease in hours, the provider must develop a new Plan of Care and notify the recipient, the caregiver, and the pre-authorization contractor. The provider must state in writing the specific reasons for the decrease, the new number of hours to be provided per week, and the effective date of the decrease in hours. The letter from the provider must include appeal rights, which can be found in the section above. A copy of this letter must be filed in the recipient's record. The provider must also send the recipient a copy of the new DMAS 97A/B. The pre-authorization contractor must also receive the new DMAS-97A/B.

If the recipient requests a decrease in hours by telephone, the RN Supervisor is not required to make an extra visit to the recipient's home. The RN Supervisor will send a letter confirming the recipient's request, the new number of hours, and the effective date of the change.

Increase in Hours

The provider is able to establish the amount of service in the Plan of Care, which is appropriate to meet the recipient's needs as long as the maximum number of hours per week for that

recipient's level of care is not exceeded. (Under no circumstances can the recipient receive more hours of care than his or her level of care allows without prior approval from the pre-authorization contractor). The provider must send a request to the pre-authorization contractor to authorize the increase if a change in the recipient's condition indicates that either (i) supervision needs to be added to the Plan of Care or (ii) the recipient's level of care has changed and an increase to the Plan of Care is needed for more than the amount allowed according to the recipient's current level of care. This contact must be documented in the recipient's record along with the date and time of the call, to whom the RN Supervisor spoke, the requested information, and the outcome of the call. The updated DMAS-97A/B and any other documentation necessary to justify the need for and use of hours may be requested by the pre-authorization contractor analyst.

The pre-authorization contractor staff will enter authorizations or denials in the computer. Once the entry has been made, the provider and recipient will receive a computer-generated letter from First Health Services notifying them of the decision and providing appeal rights if a denial is issued. Recipients have the right to appeal any adverse action taken by the pre-authorization contractor. A copy of this letter must be maintained in the recipient's record.

The provider must notify DMAS that termination is needed at any time the provider determines that a recipient does not have functional dependencies and medical or nursing needs that meet the criteria for waiver services, or that there are health, safety, or welfare issues which present an actual threat to the recipient. The provider may also discontinue services if the recipient fails to pay the primary provider the patient pay amount that is due.

The provider must notify DMAS immediately and submit documentation to DMAS, which supports the requested reason for termination. If DMAS agrees with the provider's recommendation, DMAS will terminate the authorization for services through the VaMMIS system. A computer-generated letter will be mailed to the recipient of this decision, which contains the right to appeal. If the recipient wishes to appeal the decision, the recipient must request an appeal, in writing, within 30 days of the notification of discharge. If a request for appeal is filed before the effective date of this action, services may continue unchanged during the appeal process. DMAS will notify the provider if services are to continue.

The decision letter will contain the recipient's right to formally appeal the decision by notifying the Appeals Division at DMAS.

NOTE: Failure to notify the pre-authorization contractor within 30 days that a recipient does not meet level-of-care criteria could result in a retraction of payments. If the pre-authorization contractor disagrees with the provider, the provider may discontinue its services to the recipient, but the recipient will remain open and eligible for the services from any other enrolled waiver service.

If the recipient agrees to the discontinuance of services by the provider, the provider must send a Patient Information Form (DMAS-122) to the pre-authorization contractor and a copy to the

appropriate local DSS to notify DSS of the discontinuance date, which is the provider's last date of service.

If a recipient's care was discontinued prior to his or her request for appeal and DMAS instructs the provider to reinstate services, the provider must send a copy of the pre-authorization contractor letter reinstating services, along with a DMAS-122 to DSS. The DMAS-122 must note the date of discontinuance as the last date of services rendered. The provider must make a reasonable effort to ensure continuity and appropriateness of care through referrals to any other appropriate sources of assistance.

Providers may discontinue services to individuals who are receiving personal/respite/ADHC/PERS services if the providers can no longer staff the case. If the recipient chooses to remain with the current provider while the provider attempts to hire more staff, the recipient must be informed of progress or lack of progress and alternatives. The provider must inform the recipient that if services are not received for 30 days, his or her Medicaid eligibility could be affected. The provider must also inform the recipient if services are not received for 365 days that a new screening must be completed by the local PAS Team.

Providers may discontinue services to a recipient after giving the recipient or family ten (10) days' written notification of the intent to discontinue services plus three days for mailing. The letter shall provide the reasons for and the effective date services are discontinued. This notice must <u>not</u> contain appeal rights since the recipient has not been terminated from Medicaid services.

TRANSFER OF CASES

For a transfer admission, the new provider must send to the pre-authorization contractor the DMAS-97A/B or DMAS-301, the DMAS-99, the DMAS-122, or a transferring letter from the previous provider indicating the last billable date of service, the reason for any changes made by the admitting provider to the recipient's Plan of Care, and the DMAS-100 (if the Plan of Care includes supervision time). NOTE: If the lapse in time between services is more than 180 days, the recipient's screening must be updated by the local PAS Team. If the lapse in services is 365 days or more, the recipient must be re-screened by the local PAS Team.

If the recipient's previous Plan of Care included supervision or was for hours over the recipient's level of care and the new (receiving) provider has evaluated and found that these same hours are needed; the new provider should contact the review analyst at the pre-authorization contractor to verify authorization of these hours that were previously approved, or to obtain authorization if they were not previously approved. If the new provider's Plan of Care is a decrease in hours from what the recipient was previously receiving, the provider must send the recipient a decrease notification letter. These decreased hours may be implemented if the recipient is in agreement with the new hours and Plan of Care. If the recipient disagrees with the decrease and the new Plan of Care, the hours may remain the same if the recipient files an appeal prior to the effective date of the decrease.

Transfer from Managed Care to Community-Based Care

Effective July 1, 1995, DMAS began assignment of the elderly and disabled populations into managed care programs. However, nursing facility and community-based care waiver recipients are excluded from assignment to a managed care program. Exclusion will occur once the recipient is enrolled in the Medicaid Management Information System under the Elderly or Disabled with Consumer Direction Waiver.

In the event that a Medicaid-eligible recipient who is enrolled in a managed care program is admitted to a nursing facility or community-based care program, the long-term care provider will not be able to bill for long-term care services until the recipient is disenrolled from the managed care program. To accurately exempt long-term care recipients from assignment to a managed care program, DMAS must have an accurate reporting of who is in a nursing facility or community-based care program. DMAS identifies that a Medicaid-eligible person is in a nursing facility or community-based care waiver when the provider sends the enrollment package.

In some instances, the provider may accept a referral and start care when the recipient's Medicaid eligibility is in a pended status. In these instances, continue to hold the enrollment package until obtaining a valid Medicaid number. Submit the admission documents immediately upon notification of Medicaid eligibility. If there is difficulty confirming the person's eligibility status, contact the eligibility worker's supervisor in the local agency and, if that person is unable to resolve the questions, contact the regional eligibility specialist.

Do not include any other correspondence or invoices in the enrollment packet**.** The pre-authorization contractor analyst will ensure the accuracy of all forms submitted for recipient enrollment, and that level-of-care criteria and the appropriateness of EDCD Waiver services have been met. Any packet, which is incomplete or submitted incorrectly, will be pended by the pre-authorization contractor, and the provider will be notified. Do not submit the enrollment package without a Medicaid number for the recipient.

A computer-generated letter from First Health Services will be sent to the provider confirming that the provider may now bill for services. The approved number of hours entered is from the provider Plan of Care (DMAS-97A/B). If the provider does not receive this letter within 60 days, the provider should contact the Provider HELPLINE at 1-800-556-8627 to check on the status of the enrollment. If the HELPLINE confirms that the recipient is enrolled, the provider must document in the recipient's record: the time and date, the DMAS representative to whom they talked, and the information given about the enrollment. The computer-generated letter from First Health Services is not a part of a provider's required documentation, and one cannot be duplicated. If a provider has not received one on a recipient but the HELPLINE has confirmed the enrollment, the provider should not call the pre-authorization contractor to request a copy.

Inpatient Rehabilitation Facility to Personal/Respite Care/ADHC/CD

Once a recipient has been admitted to a rehabilitation facility, regardless of the length of stay, a pre-admission screening is required prior to admission to community-based care services. The

pre-screening for inpatient rehabilitation admissions shall be completed by the local PAS Team. If a recipient receiving services from the EDCD Waiver, enters an in-patient rehabilitation facility and does not receive waiver services for 90 days or more, a new screening is required prior to the start of waiver services.

CHANGE IN SERVICES BY THE PERSONAL/RESPITE/ADHC/PERS/CDSF PROVIDER - ADVANCE NOTICE NOT REQUIRED

Personal/Respite/ADHC/PERS services may be discontinued without prior notice, if the provider's staff is in immediate danger, the recipient requests immediate discontinuation of services, or the provider does not have staff available to render care and is unable to secure a substitute aide or transfer services. However, the pre-authorization contractor must be notified first with supporting documentation; then the provider will send a letter to the recipient indicating that the provider must discontinue services. A copy of this letter must go to the pre-authorization contractor, Department of Social Services, and Adult Protective Services, if applicable. If the recipient chooses to remain with the current provider while the provider attempts to hire more staff, the recipient must be informed of progress or lack of progress and alternatives.

If the provider does not have staff, the provider must attempt to transfer services to another provider. If the recipient has adequate back-up support and requests that the provider not transfer the case, the provider may discharge the recipient from its services. However, the pre-authorization contractor must be notified first with supporting documentation; then the provider will send a letter to the recipient indicating that the provider must discontinue services. A copy of this letter must go to the pre-authorization contractor, Department of Social Services, and Adult Protective Services, if applicable. If the recipient chooses to remain with the current provider while the provider attempts to hire more staff, the recipient must be informed of progress or lack of progress and alternatives. The provider must inform the recipient that, if services are not received for 30 days, his/her Medicaid eligibility could be affected. The provider must also inform the recipient if services are not received for 365 days that a new screening must be completed by the local PAS Team.

A change in services by the provider does not include those situations in which the provider has concerns about the recipient's health and safety. In these situations, the provider must detail to the pre-authorization contractor review analyst the concerns and continue to provide services pending a decision by the analyst regarding the recipient's continued appropriateness for waiver services. If appropriate, DMAS should be contacted and a referral to Adult/Child Protective Services must be made.

When the provider determines that the recipient or the recipient's environment presents an immediate danger to personnel, the provider will issue a discharge-from-services letter to the recipient stating that services will be or have been discontinued. This letter from the provider must state the effective date of discharge and an accurate statement regarding the reason for discharge. The provider must contact the pre-authorization contractor of the discontinuation of services and the reasons for the change. The pre-authorization contractor review analyst will

promptly evaluate the situation and determine whether waiver services continue to be appropriate. If the pre-authorization contractor decides that waiver services continue to be appropriate, the pre-authorization contractor will advise the recipient to contact another approved personal/respite/ADHC/PERS/CD Service Facilitator (CDSF) provider for continued services. A copy of the letter must be filed in the recipient's record and a copy of the letter with a DMAS-122 (Patient Information Form) must be sent to the CBC Review Unit of the pre-authorization contractor. A copy of the DMAS-122 must be sent to the appropriate local DSS, giving the discontinuation date as the last date of service rendered.

RECIPIENT HEALTH AND SAFETY ISSUES

If the provider becomes aware that the services being provided and the recipient's current support system may not adequately provide for the recipient's safety, the provider should immediately contact the pre-authorization contractor review analyst to discuss the case specifics. The intent of this discussion is to determine whether the recipient's current status represents a potential risk or an actual threat to his or her safety, health, and welfare.

A potential risk is identified as deterioration in either the recipient's condition or environment, or both, which, in the absence of additional support, could result in harm or injury to the recipient.

An actual threat is the presence of harm or injury to the recipient which can be attributed to the recipient's deterioration and lack of adequate support (e.g., the recipient becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the recipient develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the provider should consider the following:

1. Is the recipient capable of calling for help when needed?
2. Is there a support system available for the recipient to call?
3. Can conditions be arranged for the recipient to care for basic needs when the support system is absent?
4. Is the recipient medically at risk when left alone?
5. Has some harm or injury to the patient been reported?
6. Does the recipient express fear or concern for his or her welfare?

If answers to the above indicate a potential risk, the provider should still advise the pre-authorization contractor of the situation. The pre-authorization contractor will decide if health, safety, and welfare are an issue and if any other referrals are necessary, for example Adult Protective Services (APS).

When a real threat to the recipient's health, safety, and welfare exists, the pre-authorization contractor will attempt to assess whether additional services can be obtained to maintain the recipient in a home environment. If continued maintenance in the home is not possible, the analyst will initiate procedures to terminate services and advise the recipient, family, or primary caregiver that nursing facility services should be considered. (Information regarding the procedures to transfer a recipient from personal care services to a nursing facility is included later in this chapter.) If the recipient or family refuses nursing facility placement, the provider must report the situation to APS. For the provider's protection, a letter from the provider should follow up a telephone call to APS. Waiver services may be terminated if a safe Plan of Care cannot be developed. Whenever a threat to the recipient's health, safety, or welfare exists, the provider is required by state law to contact APS.

SUSPECTED ABUSE OR NEGLECT

If the provider knows or suspects that an EDCD Waiver recipient is being abused, neglected, or exploited, Virginia law (§§ 63.1-55.3 and 63.1-55.4, Code of Virginia) mandates that the party having knowledge or suspicion of the abuse, neglect, and/or exploitation, report this to the local DSS. DSS (Child/Adult Protective Services) is responsible for the investigation of alleged abuse, neglect, and exploitation.

The contact with the DSS may be made anonymously, but the provider record must note the alleged abuse, neglect, or exploitation and state that the appropriate report has been made. The provider must also report the suspicions to the pre-authorization contractor, who will make a determination of whether the recipient should be discharged from the waiver.

RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Virginia currently offers two other home-based services through the Virginia *State Plan for Medical Assistance*: home health and hospice care.

Home Health

Home health services are services provided by a certified home health agency on a part-time or intermittent basis to a recipient in his or her place of residence. A recipient's place of residence does not include a hospital or nursing facility. Home health services are intended to provide skilled intervention with an emphasis on recipient/caregiver teaching. Home health services are not intended to provide long-term maintenance care. For additional information and covered home health services, refer to the Department of Medical Assistance Services Home Health Manual and Medicaid Memo dated November 5, 2004, which can be found on the DMAS website at www.dmas.virginia.gov.

Hospice Care

Hospice is an autonomous, centrally administered, medically-directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the recipient at home for as long as possible while providing the best care available to the patient, thereby avoiding institutionalization. For additional information and covered hospice services, refer to the Department of Medical Assistance Services Hospice Manual.

Simultaneous Provision of EDCD Waiver Services and Hospice Services

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. A recipient of the EDCD Waiver can receive personal care, respite care, ADHC, and PERS services in conjunction with hospice services. Waiver services must be authorized by the pre-authorization contractor.

The hospice benefit provides comprehensive services to persons with terminal illness. The hospice provider must offer homemaker/home health aide services as a part of the hospice benefit. Based upon the Medicare policy establishing the hospice reimbursement rates, it has been determined that the daily reimbursement rate covers the cost of providing a minimum of three hours per day of homemaker/home health aide services. The hospice provider must cover a minimum of 21 hours per week of homemaker/home health aide services for any recipient who requires those services. Services under the EDCD Waiver will not be available to the hospice recipient unless the hospice can document the provision of at least 21 hours per week of homemaker/home health aide services and that the recipient needs personal care-type services which exceed this amount.

Once a recipient elects the hospice benefit, the hospice becomes responsible for establishing an interdisciplinary Plan of Care designed to meet the individual needs of the recipient. If at the time of the hospice assessment, the recipient's needs indicate that more than 21 hours per week are needed, and these hours cannot be met by hospice staff, volunteers, the family support system, or other community resources, the recipient should be referred to a PAS Team. The PAS Team will evaluate whether the recipient meets the criteria for the EDCD Waiver. If a recipient is receiving waiver services at the time that he or she elects the hospice benefit, and the criteria for receiving combined services are met, the hospice provider must send a copy of the interdisciplinary team Plan of Care with the hospice enrollment forms to avoid the automatic termination of the prior waiver services authorization.

When waiver services are requested in addition to the services being provided under the hospice benefit, PAS Teams must:

- Determine the recipient's total needs for community-based care including an estimate of the daily number of hours required and document this on the Uniform Assessment Instrument (UAI) in the summary section;
- Indicate the name of the hospice involved on page 12 of the UAI and on the DMAS-97; and
- Authorize the specific waiver service, as long as the recipient will be safe in the home setting with the total amount of care available through waiver services, hospice, and informal supports.

When submitting the waiver service enrollment package to the pre-authorization contractor for pre-authorization, the provider must include a copy of the hospice interdisciplinary team Plan of Care so that the pre-authorization contractor can allow authorization for simultaneous services. The hospice must coordinate with the EDCD Waiver provider to establish and agree upon one Plan of Care for both providers that reflects the hospice philosophy and is based on an assessment of the recipient's needs and unique living situation. The recipient and service providers must be involved in any and all decisions that affect the recipient's care. If a hospice provider contracts with the agency-directed personal care provider for the 21 hours of aide service under hospice, the aide must complete an Aide Record (DMAS-90) only for the time billed to personal care.

The election of the hospice benefit is the recipient's choice rather than the hospice's choice. The hospice benefit is not designed to meet the needs of every terminally ill recipient. The recipient and family must be fully informed of the services available and any limitation on those services prior to electing the benefit. Some recipients' needs may be more effectively met by utilizing other state and local programs and services. Once a recipient has been accepted for care, the hospice may not discharge the recipient at its discretion, even if the recipient's care becomes costly or inconvenient. The recipient must sign a revocation of hospice benefits in order for him or her to be discharged from hospice services.

After admission to hospice services, the recipient may continue to receive community-based respite. The hospice benefit only provides coverage for facility-based respite and is limited to five consecutive days. The decision to choose this option is the recipient's. If the recipient wants community-based respite services, they will be allowed to use the 720 hours through the EDCD Waiver. If the recipient chooses facility-based respite, the recipient must use the hospice benefit first.

For specific questions about the provision of the EDCD Waiver and hospice services, contact either the pre-authorization contractor at 1-804-648-3159 in Richmond or at 1-800-299-9864 in all other areas or the DMAS Facility and Home-Based Services Unit at 1-804-225-4222.

UAI Updates vs. New Assessments

Pre-admission screening approvals completed by the PAS Team are valid for 365 days from the date of the approval letter. If the recipient did not receive Medicaid services in a nursing home or the EDCD or HIV/AIDS Waiver for 365 days or more, a new screening is required prior to the start of services. However, approvals older than 180 days and less than 365 days must be updated with an addendum letter specifying that the condition of the recipient has remained the same or has deteriorated since the time of the reassessment. Updates to the screening must be done by the local PAS Team.

If nursing home placement is authorized, and EDCD Waiver services are discontinued, the provider must notify (via a DMAS-122) the local DSS and the pre-authorization contractor of the date on which services were discontinued. This date should be the last day of aide service, or the last day the recipient attended ADHC.

Nursing facility pre-admission screenings should be submitted to the DMAS office as soon as the placement is anticipated rather than waiting until a bed is available. If a bed becomes available unexpectedly, DMAS must be apprised of the bed waiting status in order for the review to be expedited.

Upon review of the information submitted by the provider/CDSF, if DMAS concludes that the recipient does not meet the criteria for nursing facility admission, DMAS will notify the recipient and CD Service Facilitator that nursing facility admission is denied and will give the reason that the recipient does not meet nursing facility criteria.

A Level II assessment is also required for recipients having a Mental Illness, Mental Retardation, or Related Condition (MI/MR/RC) diagnosis. The Level II is an additional assessment procedure, which requires the assessment and authorization from the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Consequently, these screenings require an extended period of time for completion. It is vital that a diagnosis of MI/MR/RC be specifically noted in the accompanying letter when the screening request for nursing facility placement is submitted. The Level II screening must be completed prior to admission for all persons with a diagnosis or history of mental illness, mental retardation, or related conditions.

DISCONTINUANCE OF EDCD WAIVER SERVICES BY PRE-AUTHORIZATION CONTRACTOR/DMAS

The pre-authorization contractor/DMAS may discharge a recipient from EDCD Waiver services for any of the reasons stated below or for any other reason that might apply:

- EDCD Waiver services are not the critical alternative to prevent or delay institutional placement;
- The recipient no longer meets community-based care criteria;

- The recipient's home does not provide for the recipient's health, safety, and welfare; or

- An appropriate and cost-effective EDCD Waiver Plan of Care cannot be developed.

If the provider determines that any of these reasons for discontinuation exist, the provider must notify the pre-authorization contractor by contacting the CBC Review Unit. The pre-authorization contractor analyst will request that the provider submit documentation to support this determination. the pre-authorization contractor will discontinue EDCD service and forward the documentation to DMAS for a review and termination from the waiver.

The provider and the recipient will be notified in writing if waiver services are to be discontinued. The effective date of discharge will be at least 10 days from the date of the notification letter. The provider will receive a copy of the decision letter sent to the recipient. The recipient has the right to appeal any action taken by the pre-authorization contractor to discontinue services. An appeal filed by the recipient prior to the date of discharge may entitle the recipient to continued services during the appeal process. However, if the the pre-authorization contractor decision is upheld by the Appeals Division at DMAS, the recipient may be required to reimburse Medicaid for all services received following the original date of discontinuation. The provider will be notified in the event of an appeal and advised as to whether to continue previous services and bill Medicaid during the appeal process.

If the recipient elects to continue services during the appeal and makes a request for any additional service (for example: respite or ADHC) while the case is on appeal, each request will be acted upon separately by the pre-authorization contractor. If additional services are denied, the recipient will be given the right to appeal the denial of any request.

HOSPITALIZATION OF RECIPIENTS

When a recipient is hospitalized, the provider should contact the hospital discharge planner or hospital Social Services department to facilitate discharge planning. If the recipient will not be returning to community-based services, the provider must discontinue services and send a DMAS-122 to the local DSS and to the pre-authorization contractor that indicates the recipient's last date of service with the provider.

If the recipient or family member requests an increase in hours following a hospitalization, the RN/CDSF must make a post-hospitalization visit to the recipient's home and assess the need for the increase. The pre-authorization contractor will not approve an increase in hours prior to the recipient's discharge from the hospital and the in-home post-hospital assessment.

REFUSAL OF SERVICES BY THE RECIPIENT

Recipients have the right to refuse services. This refusal must be documented in the recipient record. If all services for the day are refused, the aide should leave the home and document the early departure time. If services are refused frequently, a reduction in hours may be warranted

(see "Decrease in Hours" in this chapter). This refusal must be documented by the provider in the recipient's record and an evaluation should be conducted, and the pre-authorization contractor staff should be contacted, if appropriate.

The provider may not bill Medicaid or the recipient for any time services are scheduled, but the aide is not able to provide care (e.g., the aide arrives and the recipient is not home).

CHANGE OF RESIDENCE

If a recipient's residence changes, the provider must record this in the recipient's record and notify the local DSS. This notification must be immediate and in writing.

RECIPIENTS WITH COMMUNICABLE DISEASES

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to recipients in their homes.

However, certain routine hygienic precautions designed to prevent the spread of all communicable diseases, including blood borne infections, should be taken by all providers when rendering care to any recipient, regardless of his or her known medical illness. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each recipient.

Providers are prohibited from discriminating against recipients who have been diagnosed as having Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) and other communicable diseases. Virginia offers a range of home- and community-based care services, which include personal/respite care through an approved waiver for recipients with HIV/AIDS.

PAS Teams contracted with DMAS to perform screening assessments for the HIV/AIDS Waiver are responsible for the completion of assessments. The pre-authorization contractor must perform authorization of services through the HIV/AIDS Waiver. The authorization for personal care services will <u>not</u> be made solely on diagnosis. The PAS Team will consider the appropriateness of the service based upon the recipient's meeting nursing facility criteria.

Any questions regarding this policy should be directed to the review analyst at the pre-authorization contractor by phoning 1-804-648-3159 or 1-800-299-9864.

RECIPIENTS WITH MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES, OR RELATED CONDITIONS APPROVED FOR SERVICES

Federal waiver programs are designed to serve a specific targeted population. The EDCD Waiver can only serve recipients who are at risk of nursing facility placement and meet the eligibility requirements for the waiver. The majority of recipients with a diagnosis of mental retardation, developmental disabilities, or related conditions have active treatment needs that cannot be met in a nursing facility. These recipients would be at risk of placement in an intermediate care facility for the mentally retarded (ICF/MR) rather than a nursing facility. Before any recipient with a diagnosis of Mental Retardation (MR), Developmental Disability (DD), or a Related Condition (RC) can receive services under the EDCD Waiver, the recipient must be assessed by the local Community Services Board (CSB) to determine whether active treatment needs exist. This assessment is done on the DMAS-101B. Recipients with a Mental Illness/Mental Retardation (MI/MR) diagnosis must have a DMAS-101A completed by the PAS Team and a referral made to the CSB for a DMAS-101B. The CSB evaluation and DMAS-101B must be completed prior to the PAS Team's authorizing any services on the DMAS-96.

The pre-authorization contractor will review the assessments of all recipients with MR, DD, and RC who have been approved for the EDCD Waiver to determine the appropriateness of EDCD Waiver services. EDCD Waiver services providers should not open services to any recipient with a MR, DD, or RC diagnosis until the assessment has been reviewed and deemed appropriate for services by the pre-authorization contractor. The provider must have a completed DMAS-101A and DMAS-101B on any individual with MR, DD, or RC that is being served under the EDCD Waiver.

RECIPIENTS WITH MENTAL ILLNESS APPROVED FOR SERVICES

Recipients with Mental Illness (MI) must have a DMAS-101A completed by the PAS Team and a referral made (to be evaluated by the CSB) to determine whether their primary need is for active treatment of their mental illness. Active treatment is defined as an aggressive program of specialized services geared toward "providing the recipient with as much self determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status." If the recipient's primary need is for treatment of mental illness, the recipient would be at risk of placement in an Institution for the treatment of Mental Disease (IMD) or a psychiatric hospital, rather than a nursing facility. Such recipients are not appropriate for the EDCD Waiver. Only those who have medical or nursing needs that require the level of care of a nursing facility are eligible to receive the EDCD Waiver services. The CSB will complete an assessment of active treatment needs of recipients diagnosed with mental illness on the DMAS-101B.

EXHIBITS

EXHIBITS (continued)

ELDERLY or DISABLED with CONSUMER DIRECTION WAIVER SERVICES FORMS DESCRIPTION SHEET

(The following is a description and summary of the current DMAS forms used for the EDCD Waiver. You may download these forms from the DMAS website at www.dmas.virginia.gov.)

1.	DMAS-90	Provider Aide Record (Personal & Respite Care)
	Used by the agency-directed personal care aide to document daily care tasks to the recipient. This is used for agency-directed personal and respite care only. It is to be used along side of the Provider Agency Plan of Care (DMAS-97A/B). It must be filled out, dated, and signed by the aide who is providing the hands-on care. The recipient or caregiver must sign it; if this is not possible, the reason must be documented in the recipient's file. The completed form is kept in the recipient's file at the provider agency. This is the only documentation that DMAS will use to verify that services were performed.	
2.	DMAS-90A	Skilled Respite Record
	Used by the nurse who is rendering skilled respite care to document daily care tasks to the recipient. This is used for Skilled Respite Care only. It is to be used with the Provider Agency Plan of Care (DMAS-97A/B). It must be filled out, dated, and signed by the nurse that is providing the hands-on care. The recipient or caregiver must sign it; if this is not possible, the reason must be documented in the recipient's file. The completed form is kept in the recipient's file at the provider agency. This is the only documentation that DMAS will use to verify that services were performed.	
3.	DMAS-95 Addendum	Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services
	This is to be filled out by the Pre-Admission Screening (PAS) Team for waiver recipients who are requesting CD services AND want to manage his/her own care and be the employer of the personal care aide. If the recipient has someone else manage his/her care, this form is not necessary. The form is to be included with the screening that is sent to the provider, who includes it in the admission packet to the Pre-authorization Contractor. If a recipient is receiving Waiver services and then requests CD services, the service facilitation provider completes this form and sends it to the Pre-authorization Contractor with the request for authorization.	
4.	DMAS-95B	Consumer Direction Services Management Questionnaire [Questions to consider if you want to manage consumer-directed (CD) services on behalf of a family member.]
	This form is a part of the CD Employee Management Manual. The service facilitator assists the family member who is considering managing the Plan of Care and being the employer on behalf of the Waiver recipient in filling this form out. This form is only a tool to assist the family member and not to be used for authorization of services. The facilitator does not need to keep a copy on file.	

5.	DMAS-96	Medicaid Funded Long Term Care Service Authorization Form
	It is a part of the PAS packet, and must be filled out by a Level I screener on a PAS Team. It gives pre-admission authorization to the provider on behalf of the recipient for Medicaid services, and designates the type of service the recipient is authorized to receive (i.e., a waiver, nursing home, assisted living, or PACE). It is sent to the provider agency with the screening packet, and submitted to the Pre-authorization Contractor by the provider agency as a part of the admission packet for authorization of community-based services. The original copy is to be kept in the recipient's file at the provider agency. DMAS will not reimburse for services that begin prior to the physician's signature and date on the form.	
6.	DMAS-97	Screening Team Plan of Care For Medicaid Funded Long Term Care
	Completed by the PAS Team as part of the screening process. The PAS Team will document the recipient's choice of facility placement or community-based care. The recipient/caregiver and the screener must sign and date the form. This is included with the admission packet to the Pre-authorization Contractor. The original must be kept in the recipient's file at the provider agency.	
7.	DMAS-97A/B	EDCD Provider Plan of Care
	Must be completed by the provider agency RN or CD Service Facilitator (CDSF) prior to or on the day of the initial assessment visit for all recipients. The RN/CDSF uses this to determine the level of care (amount of hours and type of services) that is appropriate for the recipient. It will also have the effective date of services and the total number of hours of service per week. The RN/CDSF must review the Plan of Care with the recipient, family and/or caregiver, and the personal care aide/LPN. It will list the services that the aide/LPN is to provide for the recipient. The RN will also complete this for an increase or decrease of hours. If the recipient transfers to another personal/respite care agency, the new provider will complete this form. A copy is to be kept in the recipient's home and a copy included in the admission packet to the Pre-authorization Contractor for authorization of services. The original is to be kept in the recipient's file at the provider agency.	
8.	DMAS-98	Community-Based Care Request for Services Form
	The provider agency, uses this form when requesting authorization or a change in the amount of services. The provider sends this to the Pre-authorization Contractor.	
9.	DMAS-99	Community-Based Care Recipient Assessment Report
	The DMAS-99B is now combined with this form. The RN Supervisor or CD Service Facilitator (CDSF) must complete it prior to or on the day of the initial assessment visit for all recipients. The RN Supervisor/CDSF uses this to assess and document the recipient's functioning status, to determine the recipient's eligibility, any changes in medical condition, hospitalizations, medical/nursing needs, and support system. The RN Supervisor/CDSF must utilize this form on every routine visit. The RN Supervisor/CDSF should read the instructions of this form to know which sections must be filled out on routine supervisory visits. The entire form must be completed on the initial assessment and during the six-month re-assessment. The form must be signed and dated by the RN Supervisor/CDSF conducting the supervisory visit and filed in the recipient's record within five days of the visit. A copy of the initial assessment must be sent to the pre-authorization contractor with the admission packet for authorization of services. All originals are to	

	be kept in the recipient's file in chronological order. This form may be used by the ADHC to document the required 30-day progress notes.	
10.	DMAS-99C	Level of Care Review Instrument
	To be filled out with the annual level of care reviews. The latest six-month assessment can be used to fill this out. DMAS will contact the provider agency when the form is to be filled out by all its active waiver recipients.	
11.	DMAS-100	Request for Supervision Hours in Personal Care
	Available with agency-directed (AD) and consumer-directed (CD) services. If a recipient is requesting supervision, the provider must fill this form out completely and send it to the Pre-authorization Contractor for authorization. The Pre-authorization Contractor must approve the request before DMAS will reimburse for this service.	
12.	DMAS-100A	Request for PERS (Personal Emergency Response System) Form
	For agency-directed (AD) and consumer-directed (CD) recipients. The PAS Team may complete this form as part of the screening process and forward it with the screening papers to the provider agency. If the recipient is requesting PERS after being admitted to personal care or ADHC, the provider agency must completely fill out this form and submit it to the Pre-authorization Contractor for authorization. The Pre-authorization Contractor must approve PERS with an authorization number before DMAS will reimburse for this service. The RN Supervisor/CDSF must document the recipient's name, Medicaid number, the provider name and number, the PERS provider name, and provider number. The recipient's cognitive status must be well detailed, especially if the recipient can be left alone. The recipient's physical incapacity must be clearly documented. The RN Supervisor/CDSF must document the recipient's current support system. The PERS provider must maintain a copy of the DMAS-100A in the recipient's file.	
13.	DMAS-101A	MI/MR Level I Supplement for EDCD Waiver Applicants
	Completed by the PAS Team as part of the screening process, the PAS Team will document if the recipient has a history of mental illness/mental retardation or a related condition. The PAS Team will document if the recipient meets nursing facility criteria. Upon completing the form, if no further assessment is required, the screening team will send it with the screening to the provider agency. If further assessment is required, the team will forward it to the local Community Services Board (CSB) for completion. A copy of the DMAS-101A must be submitted to the Pre-authorization Contractor with the admission packet. The original must be maintained in the recipient's record in the provider agency.	

14.	DMAS-101B	Assessment of Active Treatment Needs For Individuals With MI, MR, or RC Who Request Services Under the EDCD Waiver
	Completed by the local CSB, who will determine if the recipient has a mental illness or mental retardation, and the active treatment needs required for the recipient, as well as how the active treatment needs will be met. After the completion of the form, the CSB will return the form to the PAS Team who will complete the screening process and determine eligibility for the waiver based on the DMAS-101B. The form will be sent with the screening paperwork to the provider agency. A copy of the DMAS-101B must be sent to the Pre-authorization Contractor with the admission paperwork. The original must be maintained in the recipient record at the provider agency.	
15.	DMAS-122	Patient Information Form
	The provider agency completes this form when services begin or end, and sends to the local DSS to exchange information. It is the provider's responsibility to ensure that the form for the current year is in the recipient's record. The provider must send the Pre-authorization Contractor and the local DSS changes in service that warrant a new DMAS-122. The provider cannot bill DMAS prior to receiving a copy of this form. The local DSS is responsible to send a new DMAS-122 to the primary care provider (the provider with the most authorized amount of hours of care per month) annually or when patient information changes (i.e., address). The provider will include this in the admission packet to the Pre-authorization Contractor for service authorization. If the recipient is receiving services from more than one provider, the primary care provider is responsible for sending a copy of the DMAS-122 to the other provider agencies.	
16.	DMAS-300	Respite Care Needs Assessment Plan of Care
	Filled out by the PAS Team as a part of the PAS packet to indicate the need for respite services. The PAS Team will note whom the primary caregiver is, the recipients that are creating the need for respite, illnesses and limitations, whether the respite is routine or episodic, and whether an aide or LPN must perform the respite. If an LPN is required, the DMAS-300 will document what the skilled need is. There must be a physician's signature and date authorizing the skilled respite services. The recipient/caregiver must also sign and date the form. A copy of the form must be submitted with the admission packet to the Pre-authorization Contractor. The original to be kept in the recipient's record. This form is used only when respite is the sole service rendered and to be authorized.	
17.	DMAS-301	Adult Day Health Care Interdisciplinary Plan of Care
	This form must be completed by the ADHC professional staff based on the needs identified by the PAS Team and the professional staff's evaluation of the recipient's needs for nursing, transportation, nutrition, social work, rehabilitative services, PERS, and recreation services. The DMAS-301 must be completed no later than the recipient's fifth (5^{th}) visit to the ADHC. This form is used to document the goals and objectives for each of the major areas of the recipient's needs. The DMAS-301 must include the recipient's name, Medicaid number, ADHC provider identification number, signatures of the interdisciplinary team members present, the date the services actually began, and the content of the Plan of Care. At least every three months there must be an interdisciplinary staff meeting to re-evaluate the recipient, the goals, and objectives. A copy	

	of the DMAS-301 must be included in the Pre-authorization Contractor enrollment packet for authorization of community-based services. The original is to be maintained in the recipient's record at the ADHC.	
18.	DMAS-302	Adult Day Health Care Daily Log
	This form is usually completed by the program aide and must contain the specific services rendered by the ADHC staff to the recipient. The log must also contain the arrival and departure time of the recipient and a weekly signature by an ADHC professional staff member. The daily log must be completed on a daily basis, not before or after the date of delivery. At least once a week, a staff member must chart significant comments regarding the care given to the recipient. The weekly comment section must be completed unless that information is contained elsewhere in the recipient's record. If the staff member who is writing the comments is different from the staff member signing the daily log, the commenting staff member must sign the weekly comments. Rubber-stamped signatures cannot be used. All originals must be maintained in the recipient's record.	
19.	Consumer-Directed Recipient Comprehensive Training Form (Outline & Checklist)	
	The CD Service Facilitator (CDSF) uses this when providing Management Training. It is an outline of the minimum subjects that DMAS requires the CDSF to cover during the training. The CDSF must check each subject on the form after it has been covered, and have all the required signatures and dates. This form must be maintained in the recipient's files and be available for review by DMAS staff.	

PROVIDER AIDE RECORD

(Personal/Respite Care)

Recipient's Name: _____ Phone: _____

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
DATE (Month/Day/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
ACTIVITY:							
Complete/Partial Bath							
Dress/Undress							
Assist with Toileting							
Transferring							
Personal Grooming							
Assist with Eat/Feed							
Ambulation							
Turn/Change Position							
Vital Signs							
Assist with Self-Admin. Medication							
Bowel/Bladder							
Wound Care							
ROM							
Supervision							
Prepare Breakfast							
Prepare Lunch							
Prepare Dinner							
Clean Kitchen/Wash Dishes							
Make/Change Bed Linen							
Clean Areas Used by Recipient							
Listing Supplies/Shopping							
Recipient's Laundry							
Medical Appointments							
Work/School/Social							
Other							
DAILY TIME IN							
DAILY TIME OUT							
NUMBER OF HOURS							

Weekly Comments: _____

Weekly Signatures:

Recipient/Family's Signature Date

Aide's Signature Date

RN's Signature (not mandatory) Date

DMAS-90
rev. 7/05

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219

SKILLED RESPITE RECORD

Recipient's Name: _____ Medicaid ID: _____

Provider Name: _____ Provider ID: _____

Reason for Skilled Respite: _____

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
DATE (Month/Day/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
NEUROLOGICAL							
LOC A/O x3, Asleep, Awake							
CARDIAC							
Rhythm NSR, No Murmur							
Pulse / Quality Palpable in Extremities							
Edema / Cap Refill							
Invasive Lines None/CVL/PIV							
RESPIRATORY							
Rate							
Breath Sounds							
Secretions							
Chest PT							
Trach Care / Change							
Suction / Times per shift							
MONITORS							
Cardiac/Apnea – Settings							
Type / Oxygen Amt							
Vent – Settings							
C-Pap / Bi-Pap							
Blood Sugar Levels							
GASTROINTESTINAL							
Abdomen Assessment							
Bowel Sounds							
GT/NGT / Tube Patient							
TPN							
Feeds Tolerated							
GENTIOURINARY							
Spon. Voids/Diaper/Cath							
Catheter Care							
Intermittent Cath							
OTHER							
Complete/Partial Bath							
Oral Care							
Skin Care							
Skin Tugor							
Wound Care							
Turn & Position							
Medication							
Need for POC changes							
New MD Orders							

TIME IN							
TIME OUT							
NUMBER OF HOURS							

Comments:

Weekly Signatures:

Recipient/Family's Signature	Date	RN/LPN's Signature	Date
RN Supervisor's Signature (not mandatory)	Date	Print RN/LPN Name	

DMAS-90A
New 05/03

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Attachment to DMAS-90A (This form combines the DMAS-90A) rev. 03/04

INSTRUCTIONS FOR COMPLETION OF THE DMAS-90A

Agency-directed services must use this form for all RN/LPN Respite Care services. The instructions for filling out the DMAS-90A follow.

Detailed instructions for filling out the DMAS-90A for agency-directed and consumer-directed Respite services are provided below. If you have further questions, please call the Waiver Services Unit for assistance at (804) 786-1465.

It must include: the recipient's name, address, phone number, and the reason for skilled Respite.

Date: Must be a complete date, including the month, day and year.

Neurological: Level of Consciousness-is the recipient alert and oriented x3, asleep, awake, disoriented, semi-comatose or comatose. Assess the level of consciousness and document for each day Respite Care is provided.

Cardiac: The RN/LPN should auscultate the apical pulse and document the regularity of the rhythm, if there is any murmur or irregularity heard. Pulses in all extremities should be palpated and documented. Edema and capillary refill should be checked and documented. The RN/LPN should document if there are invasive lines such as Central Venous or Peripheral Intravenous.

Respiratory: The RN/LPN should note the rate of the respirations, if breath sounds are present or absent in any lobes, if the recipient has secretions, if Chest P.T. has been ordered and if so what is the order, If the recipient has a trach and if it was changed during this shift. Does the recipient require tracheal suctioning and if so how many times per shift was the recipient suctioned.

Monitors: Does the recipient utilize monitors-Cardiac or apnea monitor-what are the settings. Type of monitor and oxygen amount. Ventilator used and settings. C-Pap/Bi-Pap machine settings. Blood sugar levels.

Gastrointestinal: The RN/LPN should assess the abdomen to include distention, firm, soft as appropriate. The nurse should auscultate the bowel sounds and document presence or absence in the four quadrants. The presence of a G-tube, or NG-tube should be documented, as well as if the tube is changed during this shift. Does the recipient receive TPN feedings-what is the formula. Document if the feeding was tolerated and if not what symptoms were presented.

Genitourinary: Does the recipient spontaneously void, wear a diaper or incontinent pad, have a texas catheter, foley catheter or supra-pubic tube. Document if catheter care was provided during each shift. If intermittent catheterization is provided, document how often for each shift.

Other: Was a bath given to the recipient- document the type provided-sponge bath, partial bath, shower, tub-bath.

Oral care-does the recipient wear dentures, or were the teeth brushed. Skin care should be provided every shift or more often if required. Note any reddened areas and dry or cracked areas. Skin turgor should be checked every shift and documented. Wound care must be documented and there must be a doctors order for all wound care-what type of wound care, how often is wound care provided, describe the wound, include measurements, odor, color-wound descriptions may need to be documented under Comments. Turn and Position-this should be done at least every two hours or as often as needed.

Medication: Did the recipient receive medication during this shift. Was the medication tolerated.

Need for POC Changes: Is the Plan of Care appropriate or do changes need to be made?

New MD Orders: There must be a doctors order for all skilled services. Is there any new doctor orders-the orders may be discussed in the Comments section.

Time In: Document the arrival time to the recipient's home

Time Out: Document your departure time from the recipient's home

Number of Hours: Document the total number of hours respite care was provided to the recipient.

Comments: Include any new doctor orders, description of wounds, anything out of the ordinary that the RN supervisor or doctor should be aware of. Include any conversations/concerns of the primary caregiver, conversations with the doctor, note any issues with the environment or changes with the recipient.

Weekly Signatures: The recipient/family or primary caregiver must sign the DMAS-90A weekly to confirm services were rendered as documented.

RN's Signature: This is the RN supervisor's signature for the agency

LPN/RN Signature: Is the signature of the nurse that actually provided the respite care

Print LPN/RN Name: The name of the RN/LPN must be printed here.

Applicant's Name: _____ Date: _____

The Virginia Department of Medical Assistance Services:
Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services

To The Assessor: In addition to reviewing the applicant's ability to answer questions on the Uniform Assessment Instrument (UAI) regarding his or her status and care needs, it is necessary to question the applicant in the following areas and document the response. **Please note: applicants who have legal guardians or persons who serve as their committee are not eligible for consumer-directed services in a Medicaid Waiver.**

I. **Daily Decision-Making**

1. Did you pick out the clothes you are wearing? Please explain how you select what clothing you will wear for the day.

2. How do you plan or arrange for your meals? What kinds of things do you eat for breakfast, lunch, and dinner?

3. How do you manage your finances (pay your bills)?

4. What do you do everyday? Please tell me your daily routine.

II. **Short- and Long-Range Planning**

1. How often do you have to leave the house? If you do leave the house, how do you make appointments or schedule transportation? What transportation do you use?

2. How do you plan for a future event (for example, Christmas, family visits, etc?)

Applicant's Name: _____ Date: _____

Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services (Continued)

III. **Finding a Personal Assistant/Care Aide**

1. How will you find and hire someone to be your personal assistant/aide? What kind of person will you need to take care of your needs?

2. How will you find a replacement if a personal assistant/aide fails to come to work or quits without notice? How will you manage until you can find another aide?

3. What would you do to let someone know you needed assistance if your personal assistant/aide does not show up?

4. What steps would you take if your personal assistant/aide was abusive, or you thought the personal attendant was stealing from you?

IV. **Health Knowledge/Supports**

1. What kind of medical problems do you have? How are you currently taking care of these needs (i.e., are you seeing a doctor?) If you needed to talk to someone about a medical problem, whom would you call?

2. What kind of medications do you take and how often do you take them? What are they for?

3. Who will be providing for your medical needs other than your personal assistant/aide?

Applicant's Name: _____ Date: _____

Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services (Continued)

V. **Support Network**

1. Do you have additional support available from family, neighbors, friends, school or employers who can contact in case you have an emergency? If so, whom? How would you contact them?

_____

_____

_____

Pre-Admission Screening Team Recommendation:

☐ I recommend the applicant receive Consumer-Directed (CD) Services based on: 1) The applicant's demonstrated ability to supervise a personal assistant/ aide; and/or 2) The applicant has adequate accommodations/support that enables him or her to manage services independently. The applicant will receive personal care aide management training prior to receiving CD services.

Additional Comments: _____

(This section is applicable for applicants, who are knowledgeable about their own care, can communicate their needs to a personal care aide, and understands the rights, risks, and responsibilities of Medicaid-Funded CD services. The applicant's responses to issues related to daily decision-making, short- and long-range planning, finding an aide, health knowledge/supports, and support networks demonstrate that the applicant is capable of handling the responsibilities associated with consumer-directed services. Factors which should not influence this decision include, but are not limited to the inability to read and/or write due to a print impairment, educational level, the inability to communicate verbally, or the lack of previous experience in managing his or her health services.)

☐ I do not recommend the applicant receive CD services in the Medicaid Waiver. The applicant has little or no knowledge of his or her care requirements and could not assume the responsibilities of consumer-directed services at the present time. The applicant will be offered alternative Medicaid-funded long-term care options.

Additional Comments: _____

(This section is applicable if the applicant has little or no knowledge of his or her care requirements or consumer-directed program responsibilities. Responses in the areas of daily decision-making, short- and long-range planning, finding a personal assistant/aide, health knowledge/supports, or support networks given by the applicant do not demonstrate that the recipient would be capable of meeting program requirements of the Waiver and successfully managing CD services.)

Assessor Signature/Title: _____ Date: _____

CONSUMER-DIRECTION SERVICES MANAGEMENT QUESTIONNAIRE

(Questions to consider if you want to manage consumer directed (CD) services on behalf of a family member)

Recipient's Name *(Print)*: _____ Medicaid ID #: _____

1. Do you and your family member who is going to receive CD services generally agree on how personal care will be provided?

2. How would you describe the concepts of personal care to the family member who needs personal care?

3. How will you be able to determine the quality of work the personal assistant/aide performs?

4. If an assistant/aide did not fulfill his/her job duties adequately, what would you do?

5. What are some examples of the assistant/aide not performing his/her job duties?

6. Who would you contact if your family member was injured or mistreated by the assistant/aide?

   b. What type of action would you take if you were suspicious of mistreatment to your family member?

   c. What actions would you take once that you have discovered that your family member was injured or mistreated by the assistant/aide, even if the aide is a family member?

   b. Would you report an incident to Adult Protective Services, Child Protective Services, or another authority, even if the assistant/aide were a family member?

   ☐ Yes ☐ No

7. Would there be a reason that a family member would be hired to be the assistant/aide? If so, what would be the reason? What efforts would you make to find non-family members to be assistant/aides before you hired a family member?

8. What is your experience providing services, hiring staff, or monitoring personal care services?

9. If your family member who is receiving CD services wants you to hire other individuals or fire an assistant/aide, could you and would you?

b. Would you fire a family member? _____

Print name of family member who requests managing services: _____

Check (√) the box of the relationship that this person has with the recipient (must be one of the following):

☐ Legal Guardian ☐ Spouse ☐ Parent of a minor (under 18 yrs. old) ☐ Adult Child (18 yrs old +)

Recipient's Name *(Print)*: _____ Medicaid ID #: _____

Person completing this form *(Print name):* _____

Signature of person completing this form: _____ Date: _____

Service Facilitation Provider: _____

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name:_____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐

1 = Yes

2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.

3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐

0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?

0 = No

1 = Yes, or has applied for Auxiliary Grant

2 = No, but is eligible for General Relief ☐

Dept of Social Services:

(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care

1 = Nursing Facility Services

2 = PACE/LTCPHP

3 = AIDS/HIV Waiver Services

4 = Elderly & Disabled Waiver

10 = Consumer-Directed Personal Attendant Services

11 = ALF Residential Living

12 = ALF Regular Assisted Living

14 = Individual/Family Developmental Disabilities Waiver ☐

NOTE: Authorization for Nursing Facility, Elderly and Disabled Waiver or Consumer Directed Personal Attendant Services Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

NO MEDICAID SERVICES AUTHORIZED

8 = Other Services Recommended

9 = Active Treatment for MI/MR Condition

0 = No other services recommended

Targeted Case Management for ALF ☐

0 = No 1 = Yes

Assessment Completed ☐

1 = Full Assessment 2 = Short Assessment

ALF provider name: _____

ALF provider number: _____

ALF admit date: _____

SERVICE AVAILABILITY

1 = Client on waiting list for service authorized

2 = Desired service provider not available

3 = Service provider available, care to start immediately ☐

LENGTH OF STAY (If approved for Nursing Home)

1 = Temporary (less than 3 months)

2 = Temporary..(less than 6 months)

3 = Continuing (more than 6 months)

8 = Not Applicable ☐

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility, E&D or CDPAS Waivers. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:

1._____

☐☐☐☐☐☐☐

2._____

☐☐☐☐☐☐☐

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION

Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____

☐☐☐☐☐☐☐

0 = Not referred for Level II OR 101B assessment

1 = Referred, Active Treatment needed

2 = Referred, Active Treatment not needed

3 = Referred, Active Treatment needed but individual chooses NH ☐

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____

Level I/ALF Screener **Title** **Date**

_____ ___/___/_____

Level I/ALF Screener **Title** **Date**

_____ ___/___/_____

Level I Physician **Date**

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form* (DMAS-96)

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.

   Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.

   Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NOTE: Authorization for Nursing Facility, Elderly and Disabled Waiver or Consumer Directed Personal Attendant Services Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).

4 = **ELDERLY AND DISABLED WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.

10 = **CONSUMER DIRECTED PERSONAL ATTENDANT SERVICES** authorize only the individual meets the criteria for CDPAS Waiver services and community based service to prevent institutionalization.

11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.

12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.

14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

If ALF is authorized, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

12.

9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.

13. Targeted Case Management for ALF ***If ARC, ARR or ARI is authorized***, you must indicate whether Targeted Case Management for ALF (quarterly visits) are also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.

14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).

15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.

16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility, E&D or CDPAS Waivers. The progress notes should provided to the local departments of social services Eligibility workers.

17. Level I/ALF Screening Identification Enter the name of the Level I screening
& agency or facility (for example, Hospital, local DSS, local Health, Area Agency
18. on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.

For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*

19. If the screening is a Nursing Home Pre-Admission Screening completed in the
& locality, there should be two Level I screeners, both the local DSS and local
20. Health departments. Otherwise, there will only be one Level I screener identification entered.
Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. Level II Assessment Determination If a Level II assessment was performed (MI,
& MR or Dual), enter the name of the assessor on line 20 and the provider number
22. on line 21. *Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in*. Submit a separate DMAS-96 form.

23. Enter the appropriate code in the box.

24. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.

25. The Level I/ALF Screener must sign and date the form. **Required.**

26. The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement.**

27. The Level I physician must sign and date the form. **Required for all services except ALF placement.**

28. Enter the date the Individual entered an ALF. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.

29. Enter the name of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.

30. Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.

SCREENING TEAM PLAN OF CARE FOR MEDICAID-FUNDED LONG TERM CARE

Individual Being Screened: _____ Medicaid ID#: _____

I SCREENING TEAM DETERMINATION: Refer to Appendix B, NHPAS manual

A. **Individual Meets Nursing Facility Criteria** (Functional Dependency Level and Medical/Nursing Need Present):

☐ Yes *(must be checked to authorize Nursing Facility Placement)* ☐ No

B. **Individual is At Imminent Risk** (within 30 days of application**) of Nursing Facility Placement if Community-Based Care Is Not Offered:** ☐ Yes ☐ No

☐ Application for the individual to a nursing facility has been made and accepted. Date application was made: _____
Facility: _____ Contact: _____

☐ Deterioration in individual's health care condition or changes in available support prevents former care arrangements from meeting needs. Describe: _____

☐ Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g. recent doctor's documentation of instability, findings from medical/social service agencies). Describe: _____

Complete Section II ONLY if Nursing Facility Criteria and Risk of Waiver Services Placement are Met

II CHOICE AND PAYMENT RESPONSIBILITY

Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and will not be more expensive than nursing facility care. You may choose to receive in-home services as long as there is an available provider in your area and, either you have some additional support from family, friends, or you are able to manage without additional help when the in-home services are not being provided.

To stay at home, help in the following areas are needed (check as many as needed): ☐ ADLs ☐ Housekeeping

☐ Meal Preparation ☐ Shopping ☐ Laundry ☐ Supervision *(Attach DMAS-100)* ☐ PERS *(Attach DMAS-100A)*

☐ Transportation ☐ Skilled Needs

Please identify any people or agencies that are able to provide you with assistance, either on a regular basis or as needed:

People/Agencies	What Areas of Help Will They Provide	# Days & Hours/Week

III RECIPIENT CHOICE TO RECEIVE THE FOLLOWING COMMUNITY-BASED CARE INSTEAD OF NURSING HOME CARE

☐ Elderly or Disabled with Consumer-Direction (EDCD) Waiver

- ☐ Agency-directed Personal/Respite Care services requested _____ days/week.
- ☐ Consumer-directed Personal/Respite Care services requested _____ days/week.
- ☐ Both *(agency- & consumer- directedservices)*
- ☐ Adult Day Health Care services requested _____ days/week from _____ a.m. to _____ p.m.
- ☐ Combination of Services *(☐ ADHC ☐ Agency-directed personal/respite care ☐ Consumer-directed personal/respite care)*
- ☐ Transportation is needed for ADHC services

_____ *(Provider Agency)* has been chosen and contacted and is able to provide the services requested. I understand that the provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous, reliable care, but there may be an occasional lapse in service for which I will need to provide back-up support. (Under consumer-directed services, I understand the responsibilities associated with employing my own personal attendants). I understand that, based on my income, I may have a co-pay of $_____/month, regardless of the amount of community-based care received.

Client Signature	Date	Screener's Signature	Date

IV NURSING FACILITY CHOICE AND PAYMENT RESPONSIBILITY

Community-based care alternatives were explained completely but were not an option for me because _____

I choose to receive nursing facility care and requesting admission to _____(facility).
I understand that I may have to pay $ _____/ mo. in order to receive nursing facility care. Community-based/in-home care has been explained completely and I understand the options for services that are available? ☐ Yes ☐No

Client's Signature	Date	Screener's Signature	Dating

DMAS-97 revised 020105

Instructions For Completing the DMAS-97

Complete this form only if you are authorizing nursing facility or Community-Based Care services.

Section I: Screening Determination

Item A must be checked if authorizing Nursing Facility Placement

Item A or at least one of the conditions in B must be completed if authorizing Community-Based Care Services

Section II: Community Care Choice and Payment Responsibility

Section II must be completed in its entirety if Community Based Care criteria is met and client chooses Community Based Care Services. Please remember to obtain client's signature that assures the client was given a choice of providers and was advised of their possible patient pay responsibility.

The screener must check services that the recipient will need in order to remain at home.

The screening committee must explain to the client that the screening committee does not authorize the amount of services or times of day or days of week on which services will be provided. The provider agency will make that decision with the client based on their needs and wishes identified during the screening.

Section III: Nursing Facility Choice and Payment Responsibility

Section III must be completed in its entirety if Nursing Facility Criteria is met and the recipient chooses Nursing Facility Placement. Please remember to obtain client's signature that assures the client was offered Community-Based Care alternatives and chooses Nursing Facility Placement

ELDERLY OR DISABLED WITH CONSUMER DIRECTION PROVIDER PLAN OF CARE

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* _____

Recipient Name: _____ Medicaid ID#: _____
Provider Agency: _____ Provider ID#: _____

WRITE THE AMOUNT OF TIME FOR EACH TASK TO THE NEAREST 15 MINUTES. ADD TOTAL TIME FOR EACH CATEGORY

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL's Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. Special Maintenance Vital Signs							
Supervise Meds							
Range of Motion							
Wound Care							
Bowel/Bladder Program							
Total Time:							
3. Supervision Time							
4. IADLS Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Recipient							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/ Social							
Total IADLS Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this recipient.)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help/ w/MH only	0	Continent / incontinent < weekly self care of	
Walks/Wheels w/ HH or HH & MH	1	internal / external devices	0
Totally dependent for mobility	2	Incontinent weekly or > Not self care	2

LEVEL OF CARE: (LOC)	☐ **A** (Score 0 - 6) Maximum Hours of 25/Week	☐ **B** (Score 7 - 12) Maximum Hours 30/Week	☐ **C** (Score 9 + wounds, tube feedings, etc.) Maximum Hours 35/Week

The Amount of Time Needed to Complete All Tasks must Not Exceed The Maximum For the Specified LOC Category.

Recipient Name: _____ Medicaid ID#: _____
Provider Agency: _____ Provider ID#: _____

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide: _____

_____

Backup Plan (Person's name): _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Recipient / Care Giver Signature: _____ Date: _____

RN or SF Signature _____ Date: _____

Instructions for the DMAS-97A/B (10/04)

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the provider agency is unwilling or unable to change the information that you disagree with, you have the right to an appeal by notifying, in writing, The Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (effective date), services may continue unchanged during the appeal process.

Instructions for Completion of the DMAS-97A/B

Category/Tasks
Write the amount of time for each task to be done to the nearest 15 minutes. This should be done each task for each day. Then put the total time for each category, for each day.

Level of Care Determination For Maximum Weekly Hours
Enter a score for each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC.

Provider Notification To Client
Anytime the RN Supervisor or Service Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require WVMI approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to appeal. The client should get a copy of both the front and back of the form.

WVMI Notification To Client
If the changes to the Plan of Care require WVMI approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to WVMI for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS-100). Supervision is for Agency-Directed Personal Care services only. Once received by WVMI, the analyst will review the care plan and indicate whether the request is pended, approved, or denied. The recipient will receive by mail the decision letter from First Health.

Recipient / Care Giver Signature
The recipient's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care.

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the person you contact is unwilling or unable to change the information you disagree with, you have the right to request reconsideration by notifying, in writing, the Community-Based Care Supervisor, WVMI, 6802 Paragon Place, Suite 410, Richmond, Va. 23230. This written request for reconsideration must be filed within thirty (30) days of the time you receive this notification. If you file a request for reconsideration before the effective date of this action, _____ (effective date), and services may continue unchanged during the reconsideration process.

Instructions for Completion of the DMAS-97-A

Level of Care Determination For Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC.

Provider Notification To Client

Anytime the RN Supervisor changes the plan of care that results in a change in the total number of weekly hours, the RN must complete the entire front section of this form. If the change the agency is making does not require WVMI approval, the RN Supervisor is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to reconsideration and make sure the client gets a copy of both the front and back of the form.

WVMI Notification To Client

If the changes to the Plan of Care require WVMI approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to WVMI for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS-100). Once received by WVMI, the analyst will review the care plan and indicate whether the request is approved or denied. Once the decision is made, the DMAS-98 form will be sent back to the provider agency who is responsible for making sure the client receives a copy of the form which gives the client's right to appeal and the front of the care plan.

6802 Paragon Place II
Suite 410
Richmond, Virginia 23230
Ph: 1-804-648-3159
Toll Free: 1-800-299-9864

COMMUNITY BASED CARE
REQUEST FOR SERVICES FORM

Fax: 1-804-648-6992
Toll Free: 1-866-510-7074

___ New Request
___ Pend Response
___ Change to Approval –Must include PA# on this form.
PA # _____

Recipient Medicaid #_____ Name: (last)_____(first)_____

Recipient Phone # (Attendant Care and Consumer Directed Respite Only) (_____)_____-_____SS# _____-_____-_____ DOB: _____/_____/_____

Provider #_____ Provider Name: _____ Waiver: _____

Contact Person: _____ Phone #_____ _____ Fax: _____

Request Information:

Provider Number	Provider Name	National Code	Type	Units	Effective Date
_____	_____	_____	____	_____	____/___/_____
_____	_____	_____	____	_____	___/___/_____
_____	_____	_____	____	_____	____/___/____

Date DMAS 122 received by Provider: ___/___/____

Waiver Enrollment: DD or MR (Circle One) **Last Date of service:** ____/___/____

WVMI Use Only:

Hours	Effective Date	Status	PA #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	____	_____
_____	_____	____	_____

WVMI Use:
Date / Reviewer
___/___/____ / _____
___/___/____ / _____
___/___/____ / _____
___/___/____ / _____

Any pended preauthorization request cannot be processed due to missing, incomplete or illegible information. **WVMI Tracking Number:** _____
Please attach *only* the requested information to WVMI within 14 days. This does not require resubmission of the entire package.
Any rejected preauthorization request requires re-submission of the entire request package within 10-days of the start of care (or receipt of the DMAS 122).

Provider Comments:

WVMI Comments:

Instructions for Completion of the WVMI Request for Services Form

This form is intended to summarize the services requested on the screening forms and must be completed when submitting requests to WVMI by facsimile or mail.

Demographic Information:

Recipient Medicaid #: Enter 12-digit recipient ID number
Name: Complete recipient name as it appears on the Medicaid card
Recipient phone number is required for EDCD recipients
Recipient Social Security Number
DOB: Enter the recipient date of birth.
Waiver: Enter name of Waiver enrolled.
Provider #: Enter 9-digit provider number
Provider Name: Enter name of provider of services being requested
Contact Person: Enter provider agency name to contact for further information
Phone/Fax Numbers: Enter number with area code
PA #: Enter Prior authorization number you wish to make changes to

Request Information:

Provider #: Enter 9-digit provider number
Provider Name: Enter name of provider of services being requested
National Codes: Enter the national code for services requested. The following abbreviations may be used:

EDCD Waiver:

S5102	Adult Day Health Care
S5160	PERS Installation
S5161	PERS Monitoring
S5160 U1	PERS Med Monitoring/ Installation
T1019	Personal Care (Agency)
T1005	Respite Care/aide (Agency)
S9125 TE	Respite Care/skilled nurse (Agency)
S5185	PERS & Med Monitoring
H2021 TD	PERS Nursing/RN
H2021 TE	PERS Nursing/LPN
S5126	CD Personal Care (attendant care)
S5150	CD Respite

HIV/AIDS Waiver:

T1016	Case Management
T1005	Respite Care/Aide
T1002	Private Duty Nursing/RN
T1003	Private Duty Nursing/LPN
T1019	Personal Care
S9125 TD	Respite Care RN
S9125 TE	Respite Care/ LPN
S5126	CD Attendant Care
S5150	CD Respite
B4154	Enteral Nutrition

Elderly Case Management

T1016 Elderly Case Management

Type: Complete type of request by indicating the letter for the corresponding services
E: Enrollment I: Increase D: Decrease T: Transfer D/C: Discharge
Units/Hours: Complete hours/units for the services being requested
Effective Dates: Complete the effective date for services requested.
Date DMAS 122 Received by Provider: If the request is not submitted to WVMI within 10 business days of the start of care, the date the DMAS 122 was received by the provider **must** be entered.
Discharge (Last date of services) for: Complete to allow discharge from current provider/waiver for enrollment into another waiver- must enter **DD Waiver** or **MR Waiver**. Effective date is the current providers LDOS.

Community-Based Care Recipient Assessment Report

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* _____

☐ Initial Visit ☐ Routine Visit ☐ Six-Month Re-assessment

Recipient's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Recipient's Current Address: _____ Agency Name: _____

_____ Provider ID #: _____

Recipient's Phone: ( ) _____ Recipient's SSN#: _____

FUNCTIONAL STATUS

ADLs	Needs No Help	MH Only	Human Help		MH & Human Help		Always Performed By Others	Is Not Performed At All
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION

Oriented	Disoriented-Some Spheres/Sometimes	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Times	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior:

Source of Info:

JOINT MOTION
___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

MED. ADMINISTRATION
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

MEDICAL/NURSING INFORMATION

Diagnoses: _____

Medications: _____

Current Health Status/Condition: _____

_____

Current Medical Nursing Needs: _____

_____

Therapies/Special Medical Procedures: _____

_____

Hospitalizations: Date(s): _____ Reason(s): _____

_____

Recipient Name: _____ Date of Assessment: _____

SUPPORT SYSTEM

Waiver services the recipient is receiving, and the provider agency, at the time of the visit (check all that apply):
☐ Agency Personal Care: _____ ☐ CD Personal Care _____
☐ Agency Respite _____ ☐ CD Respite _____
☐ ADHC _____ ☐ PERS _____
What Waiver service is the patient pay to be deducted? _____
Hours the aide provides care to the recipient: Total Weekly Hours: _____ Days Per Week: _____
Specific Hours the aide is in the recipient's home: _____
Other Medicaid/non-Medicaid funded services received: _____
_____
Who is the primary care giver(s): _____
Does the primary care giver live with the recipient: ☐ Yes ☐ No Relationship to recipient: _____
Who other than the recipient is authorized to sign the aide records? _____
Is the recipient receiving PERS?: ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor?: ☐ Yes ☐ No

If the recipient has PERS and/or Medication Monitoring, answer the following questions:

Is the recipient 14 years of age or older?: ☐ Yes ☐ No
Is PERS adequate to meet the recipient's needs?: ☐ Yes ☐ No
Is there time when the telephone service is disconnected?: ☐ Yes ☐ No
Is the recipient pleased with the service from PERS provider? ☐ Yes ☐ No

CONSUMER-DIRECTED SPECIFIC:

Person directing/managing the care: _____ Relationship to recipient: _____
Person providing the care: _____ Relationship to recipient: _____
Is the recipient in need of PERS at all times to be maintained safely?: ☐ Yes ☐ No

AGENCY-DIRECTED SPECIFIC:

Is the recipient in need of supervision or PERS at all times to be maintained safely?: ☐ Yes ☐ No
Is the recipient receiving supervision?: ☐ Yes ☐ No If yes, has he/she been informed of PERS (if applicable) ?: ☐ Yes ☐ No

SERVICE FACILITATOR / RN SUPERVISION

Dates of RN supervisory / SF visits for the last 6 months: _____
Frequency of supervisory visits (30 to 90 days): _____
Did the recipient/caregiver agree to frequency of visits, and is it documented in the recipient's file? ☐ Yes ☐ No
Does the aide document accurately the care provided? ☐ Yes ☐ No
Does the Plan of Care reflect the needs of the recipient? ☐ Yes ☐ No
If No to either, please describe follow-up: _____
_____

CONSISTENCY AND CONTINUITY

Number of days of no service in the last 6 months: (Do not include hospitalizations) _____
Number of aides assigned to the case in the last 6 months: Regular Aides: _____ Sub-Aides: _____
Has the recipient or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If yes, please describe problem(s) and the follow-up taken: _____
_____
Is the recipient satisfied with the service he/she is receiving by the provider agency?: ☐ Yes ☐ No If no, please describe and the follow-up taken: _____
_____

Date of most recent DMAS-122: _____ Patient Pay Amount (if applicable): _____

Aide Present During Visit? ☐ Yes ☐ No Name of Aide: _____
Regular Aide ☐ OR Sub Aide/Assistant ☐

SF / NURSING NOTES: *(if additional space is needed, use the back or add attachment)*

_____
_____
_____
_____
_____

RN / SF SIGNATURE: **DATE:**

INSTRUCTIONS FOR COMPLETION OF THE DMAS-99

Agency-directed services must have use this form for all RN supervisory visits conducted for Personal and Respite Care services. The instruction for filling out the DMAS-99 may vary with the type of visit that is conducted. Check the appropriate box at the top of page one. Whether the service is agency-directed or consumer-direct, the Initial and the Six-Month Re-assessment visit require the entire DMAS-99 to be filled out completely. The Routine Supervisory Visit may allow an update of the previous routine supervisory visit's information.

Detailed instructions for filling out the DMAS-99 for agency-directed and consumer-directed services are provided below. If you have further questions, please call the Waiver Services Unit for assistance at (804) 786-1465.

AGENCY-DIRECTED SERVICES
THE INITIAL AND SIX-MONTH REASSESSMENT VISIT

It must include: the recipient's name, address, date of birth, phone number, Medicaid ID number, the start of care date, and the provider agency's name and provider number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The recipient's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) user's manual when assessing the recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the RN should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient does not need an aide to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the recipient's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the Initial and Six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the recipient should be noted on this visit. Remember that the recipient may have developed another medical complication requiring the documentation of another diagnosis. MEDICATIONS: List the individual's medications. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the recipient's condition has improved, declined, or remained stable. The RN must assess this issue by asking pointed questions, (e.g., have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the RN or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the recipient's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care, support system and/or the need for supervision should be noted. WAIVER SERVICES - List all that the recipient is receiving. Check the box and write the name of the provider agency supervising/rendering the service. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- List those that the recipient is receiving, which may include, but not be limited to, Meals on Wheels, companion services, Adult Day Health Care, and etc. WHO WILL BE RESPONSIBLE FOR SIGNING THE AIDE RECORDS- If the recipient is cognitively impaired, note who this includes, i.e., family, friends and/or significant other. If someone other than the recipient will be signing the aide record, that person should be instructed to sign his/her own name, not the recipient's name. If the person signing the aide record(s) is not the primary caregiver, the nurse should note on the DMAS-99 that this person has authorization to sign for the recipient. IS THE RECIPIENT IN NEED OF SUPERVISION- If the supervision is provided solely by the recipient's caregivers, the Request for Supervision Form is *not* required. If, however, supervision hours are provided on the recipient's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the recipient's record. If the recipient requires supervision at all times and the caregivers are not available at all times, has the recipient been informed about the Personal Emergency Response System (PERS), if it is a covered service in the waiver? The recipient must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the recipient has PERS, the related questions in this section must be answered.

RN SUPERVISION: Dates of RN supervisory visits for the last six months must be completed on the six - month reassessment. The accuracy of the aide documentation must be noted with every routine supervisory visit and should directly correlate with whether the aide is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. The Frequency of the supervisory visit that was agreed upon between the RN and the recipient must be documented. This frequency can be from 30 to 90 days, for recipients without a cognitive impairment as defined by DMAS policy. If the RN's plan of care is not being followed by the

aide due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer one or both questions as "NO". Any **"NO" answers** must be explained including how the plan of care will be changed to meet the recipient's needs.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the recipient/caregiver requested to be without service or days the recipient was hospitalized. Note how many aides have been assigned over the past six months as well as how many substitute aides were utilized. If the recipient or caregiver(s) has been dissatisfied with the aide, RN, agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed)

Record the date and patient pay amount (if applicable) from the most recent DMAS 122.

The RN/Coordinator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the RN's signature when conducting utilization review. The DMAS-99 must be filed in the recipient's record within five days of the date of the last visit. If an aide was present in the home at the time of the visit, note the aide's full name and whether the aide is regularly assigned or is being utilized as a substitute aide on this day.

NURSING NOTES: Nurses may utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

AGENCY-DIRECTED ROUTINE RN SUPERVISORY VISITS:

The recipient's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If the RN determines that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed on every routine supervisory visit and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the recipient's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the recipient meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission.

SUPPORT SYSTEM: Any changes regarding hours on the plan of care, support system and/or need for supervision should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services the recipient is receiving may include (but not be limited to) meals on wheels, companion services, Adult Day Health Care, and etc. If the recipient is cognitively impaired, who will be responsible for signing the aide records must be noted and may include family, friends and/or significant other. If the recipient is in need of supervision at all times but supervision is provided solely by the recipient's caregivers, the Request for Supervision Form is *not* required. If supervision hours are provided on the recipient's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the recipient's record. If the recipient requires supervision at all times but caregivers are not available at all times, has the recipient been informed about PERS, if it is a covered service in the waiver? The recipient must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the recipient has PERS, the related questions in this section must be answered.

RN SUPERVISION: The accuracy of the aide documentation must be noted on every routine supervisory visit and should directly correlate with whether the aide is following the recipient plan of care, or if not, documenting the reason(s) for not following the plan of care. If the RN's plan of care is not being followed by the aide due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer one or both questions as "NO". Any "NO" answers must be explained including any changes to the plan of care to meet the recipient's needs.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the aide, RN, agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS 122.

The RN/Coordinator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the RN's signature when conducting utilization review. The DMAS-99 must be filed in the recipient's

record within five days of the date of the last visit. If an aide was present in the home at the time of the visit, note the aide's full name and whether the aide is regularly assigned or is being utilized as a substitute aide on this day.

NURSING NOTES: Nurses may utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

CONSUMER-DIRECTED SERVICES
THE INITIAL AND SIX-MONTH REASSESSMENT VISIT

It must include: the recipient's name, address, date of birth, phone number, Medicaid ID number, the start of care date, and the provider agency's name and provider number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The recipient's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) user's manual when assessing the recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the CDSF should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient does not need an aide to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the recipient's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the initial and six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the recipient should be noted on this visit. Remember that the recipient may have developed another medical complication requiring the documentation of another diagnosis. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the recipient's condition has improved, declined, or remained stable. The CDSF must assess this issue by asking pointed questions, (e.g., have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the CDSF or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the recipient's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care or the support system should be noted. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- This must be filled out. PERSON PROVIDING THE CARE- If the recipient has someone managing his/her POC, the person's full name. PERSON DIRECTING THE CARE – The full name of the personal assistant providing the care. The person directing the care and the assistant cannot be the same person.

SERVICE FACILITATOR SUPERVISION: Dates of Facilitator's supervisory visits for the last six months must be completed on the six-month reassessment. Document if the assistant is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. If the Facilitator's plan of care is not being followed by the assistant due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the recipient/caregiver requested to be without service or days the recipient was hospitalized. Note how many assistants have been assigned over the past six months as well as how many substitute assistants were utilized. If the recipient or caregiver(s) has been dissatisfied with the assistant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Record the date and patient pay amount (if applicable) from the most recent DMAS 122.

The Facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the Facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient's record within five days of the date of the last visit. If an assistant was present in the home at the time of the visit, note the assistant's full name and whether the assistant is regularly assigned or is being utilized as a substitute assistant on this day.

SERVICE FACILITATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

CONSUMER-DIRECTED ROUTINE FACILITATOR SUPERVISORY VISITS:

The recipient's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If it is determined that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed monthly and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the recipient's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated monthly on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the recipient meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission.

SUPPORT SYSTEM: Any changes regarding hours on the plan of care or the support system should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services should be filled out.

SERVICE FACILITATOR SUPERVISION: document if the assistant is not following the plan of care and the reason(s) why. If the Facilitator's plan of care is not being followed by the assistant due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the assistant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS 122.

The facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient's record within five days of the date of the last visit. If an assistant was present in the home at the time of the visit, note the assistant's full name and whether the assistant is regularly assigned or is being utilized as a substitute assistant on this day.

SERVICE FACILITATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

LEVEL OF CARE REVIEW INSTRUMENT

The assessment cannot be more than six (6)-months old.
(Use Instructions on page three to complete this form correctly.)

SSN #: _____ AIDS Waiver? ☐ Yes ☐ No Assessment Date (MM/DD/YYYY): _____

Last Name: _____ First Name: _____ MI: _____ Suffix (circle): Mr. / Ms./ Mrs.

Enrollee ID # (Recipient): _____ Age: _____ Enrollee Ph: ( ) _____

Provider ID #: _____ Provider Phone #: ( ) _____

If the recipient receives more than one service from your agency, you only need to fill out one form but list all provider numbers in the area above.

Enrollee Address: _____ City: _____ Zip: _____

WAIVER

Recipient Admission Date (Start of care date with service provider): _____ (MM/DD/YYYY)

☐ EDCD (*Specific service(s), check all that apply*): ☐ Personal Care ☐ Respite Care ☐ ADHC ☐ PERS

☐ CDPAS Personal Care ☐ CDPAS Respite Care

☐ AIDS (*Specific service, check all that apply*): ☐ Case Management ☐ Enteral Nutrition ☐ PDN

☐ Personal Care ☐ Respite Care ☐ Consumer-Directed

DEMOGRAPHICS (COMPLETE ALL SECTIONS)

Case Mgmt: _____ Transport: _____ Housing: _____ Congregate: _____ Marital Status: _____ Subst Abuse: _____

Home Repairs: _____ Com of Needs: _____ Personal Care: _____ Home Deliver: _____ Adult Protect: _____

Hearing Impaired: _____ Vocational: _____ Respite: _____ Home Health: _____

Adult Daycare: _____ Other Services: _____

FINANCIAL RESOURCES (CHECK APPROPRIATE BOXES)

Medicaid Insure: ☐No - 0 ☐ Yes - 1 Medicare Insure: ☐ No - 0 ☐ Yes - 1 Medicaid Pending: ☐ No - 0 ☐ Yes - 1

PHYSICAL ENVIRONMENT / FUNCTIONAL STATUS (CHECK APPROPRIATE LEVEL – ONLY 1 CHECK PER ROW)

ADLs (Check appropriate level)	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist 32	Always Performed By Others - 40	Not Performed At All - 50
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

Continence (Bowel/Bladder)	Continent 00	Incontinent (Less than weekly) - 1	External Device/ Indwelling/Ostomy (Self care) – 2	Incontinent (Weekly or more) 3	External Device (Not self care) 4	Indwelling Catheter (Not self care) - 5	Ostomy 6
Bowel							
Bladder							

Mobility (Check appropriate level)	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist. 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist. 32	Confined Moves About 40	Confined - Does Not Move About 50

IADLs				
	Meal Prepare: ☐ N-0 ☐ Y-1	Housekeeping: ☐ N-0 ☐ Y-1	Laundry: ☐ N-0 ☐ Y-1	Money Mgmt: ☐ N-0 ☐ Y-1
	Transport: ☐ N-0 ☐ Y-1	Shopping: ☐ N-0 ☐ Y-1	Using Phone: ☐ N-0 ☐ Y-1	Home Maintenance: ☐ N-0 ☐ Y-1

PHYSICAL HEALTH ASSESSMENT (CHECK APPROPRIATE LEVEL)

Joint Motion	**Med. Administration / Take Medicine**
☐ Within normal limits or instability corrected – 0	☐ Without assistance – 0
☐ Limited motion – 1	☐ Administered/monitored by lay person – 1
☐ Instability uncorrected or immobile - 2	☐ Administered/monitored by professional nursing staff - 2

Orientation **(Check appropriate box)**	Oriented-0	Disoriented-Some Spheres/SomeTimes -1	Disoriented-Some Spheres/All Times-2	Disoriented-All Spheres/Some Times-3	Disoriented-All Spheres/All Times-4	Semi-Comatose /Comatose-5
Behavior **(Check appropriate box)**	Appropriate 0	Wandering/Passive Less than Weekly 1	Wandering/Passive Weekly or more 2	Abusive/Aggressive/ Disruptive Less than Weekly - 3	Abusive/Aggressive/ Disruptive Weekly or more - 4	Semi-Comatose to Comatose - 5

Ambulation	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist 32	Always Performed By Others - 40	Not Performed At All - 50
Walking								
Wheeling								
Stair climbing								
							Confined Moves About	Confined D/N Move About
Mobility								

PSYCHO-SOCIAL ASSESSMENT (CHECK APPROPRIATE BOX)

Hospitalization or Alcohol/Drug Center: ☐ NO – 0 ☐ YES - 1

ASSESSMENT SUMMARY (CHECK APPROPRIATE ANSWERS)

Is there an informal caregiver? ☐ NO – 0 ☐ YES - 1 | Caregiver Support: ☐ Adequate - 0 ☐ Not Adequate - 1

If No Informal Caregiver or Caregiver Support Not Adequate – List backup plan:

Where does the caregiver Live? ☐ With client - 0 ☐ Separate residence, close proximity – 1 ☐ Separate residence, over 1 hour away - 2

MEDICAL / NURSING NEEDS (COMPLETE ALL SECTIONS)

Diagnosis: _____

Current Health Status/Condition/Comments: _____

_____

_____

Current Medical Nursing Need(s) – Check all items that apply:

1 ☐ Application of aseptic dressings (a)
2 ☐ Routine catheter care (b)
3 ☐ Respiratory therapy (c)
4 ☐ Therapeutic exercise and positioning (d)
5 ☐ Chemotherapy (e)
6 ☐ Radiation (f)
7 ☐ Dialysis (g)
8 ☐ Suctioning (h)
9 ☐ Tracheotomy care (i)
10 ☐ Infusion Therapy (j)
11 ☐ Oxygen (k)
12 ☐ Routine skin care to prevent pressure ulcers for individuals who are immobile. (l)
13 ☐ Care of small uncomplicated pressure ulcers, and local skin rashes (m)
14 ☐ Use of physical (e.g., side rails, poseys, locked wards) and/or chemical restraints. (n)
15 ☐ Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability (o)
16 ☐ Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder (p)
17 ☐ Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration (q)
18 ☐ The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals. (r)
19 ☐ Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists. (s)

 Recipient Name: _____

AIDS Waiver Only: AIDS/HIV diagnoses: ☐ Yes ☐ No

PC/RC - Weekly Hours: _____ ADHC - Number of Days Per Week: _____

Comments: _____

_____

_____

_____ _____

Signature of Person completing the DMAS-99C **Date the DMAS-99C was completed** (MM/DD/YYYY)

_____ _____

Print legibly Name & Title **If this form is not being completed by the RN – Print legibly the name of the RN who made the referenced visit**

INSTRUCTIONS FOR COMPLETING THE DMAS-99C

1. A copy of this form (DMAS-99C) must be completed in its entirety for each current waiver recipient that is admitted under your agency's Medicaid provider number. The instructions to fill out each category correctly are explained below. If you need further instructions about the meaning of a question on this form, look at the UAI manual located at: www.dmas.state.va.us.
2. The provider must attach a copy of the recipient's current: Provider Agency Plan for Personal & Respite Care (DMAS-97A), Consumer-Directed Services Plan of Care (DMAS-97B), the Adult Day Health Care Interdisciplinary Plan of Care (DMAS-301), or the AIDS Waiver Case Management Plan of Care (DMAS-114).
3. The forms are to be mailed to DMAS within the time frame designated on the cover letter. Each provider will receive a cover letter with a list of current recipients and a due date to mail all requested documentation. Due to HIPAA requirements, we cannot accept the forms through electronic mail. In addition, due to the volume, we request that you do not fax the documents, but send them through the U.S. Mail to: The Department of Medical Assistance Services
   F&HBSU – Level of Care Reviews
   600 East Broad Street, Suite #1300
   Richmond, VA 23219
4. **Assessment Date**: The date that the RN did the last 6-month Assessment that is being used to fill this form out.
5. **Waiver**: Check the waiver and the service(s) the recipient is receiving in the waiver.
6. **Demographics**: Place a Yes or No for the four following categories and the other categories not specifically listed below.
   Congreg: Does the client receive congregate meals outside the home? Yes or No
   Home Deliver: Does the client receive meals delivered to his home? Yes or No
   Hearing Impaired: Does the client have a hearing impairment of any type? Yes or No
   Transport: Does the client have current formal paid transportation? Yes or No
   Place the appropriate number following each of the three categories.
   Housing: 0-Own House; 1-Rent House; 2-House Other; 3-Apartment; 4-Rented Room
   Marital Status: 0-Married; 1-Widowed; 2-Separated; 3-Divorced; 4-Single; 9-Unknown
   Com of Needs: 0-Verbally in English; 1-Verbally in Other Language (write in language spoken); 2-Sign Lang/Gestures/Device; 3-Does not Communicate.
7. **Financial Resources**: Check the appropriate box.
8. **Physical Environment / Functional Status:** Check only one box in each category. (Do not write in comments in this section).
   ADLs: Check the appropriate box. Continence / Bowel & Bladder: Check the appropriate box.
   IADLS: Check the appropriate box. These items pertain to whether the client needs help in these areas.
   Mobility: Check the appropriate box.
9. **Physical Health Assessment:** Check the appropriate boxes. (Do not write in comments in this section).
10. **Psycho-Social Assessment**: Check appropriate box. (Do not write in comments in this section).
11. **Assessment Summary**: Check appropriate boxes. (Do not write in comments in this section unless explaining backup plan).
12. **Medical / Nursing Needs:** Describe the current health status/condition of the recipient and check the medical nursing need or write down the nursing need(s) of the recipient. Something must be checked to show recipient's Medical/Nursing eligibility.
    AIDS Waiver Only: Check the appropriate box. Aide's Weekly Hours: The number of weekly hours on the Plan of Care.
    Aide's Number of Days Per Week: The number of days a week that the Plan of Care schedules the aide to work.
13. **Comments:** Any information on the recipient's care, medical condition, or status that relates to his eligibility or utilization of hours.
14. **Reference:** Refer to Chapter 4 - exhibits of the Waiver Manual for eligibility criteria prior to completing this form.
15. **DO NOT leave sections blank - complete the entire form. Read and follow all directions carefully.**

 Recipient Name: _____

REQUEST FOR SUPERVISION HOURS IN PERSONAL CARE

Recipient Name: _____ Medicaid ID: _____

Primary Provider: _____ Provider Number: _____

I. RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY NEED FOR SUPERVISION

A. **Cognitive Status:** Describe the recipient's cognitive status and impact it has on his/her behavior. If the recipient is confused at different times of the day, please explain. State whether the recipient can/cannot be left alone. If the recipient can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the recipient have appropriate judgement/decision making abilities? *(Be as detailed as possible. It is important that the RN make a correct appraisal of the cognitive status of the recipient. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.)*

B. **Physical Incapacity:** Describe the degree of physical incapacity and how it justifies a need for supervision.

1. Incontinence:
   Bowel: _____ Frequency of Changes: _____
   Bladder: _____ Frequency of Changes: _____
2. Can the recipient change position/shift/transfer without assistance?
3. Skin Breakdown (*Note areas affected/recently documented problems within the last year, including dates*):
4. Potential for skin breakdown (*Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.*):
5. Falls [*Describe any falls that have occurred during the past 3 months, including dates and times of fall(s), and the scenario of the fall(s). Interactions and side effects of medications that may have contributed to the fall(s) must be included. Document what interventions, if any, have been put in place to prevent future falls.*]:

C. The recipient can call (via telephone) for assistance: ☐ Yes ☐ No
If No, explain: _____

6. Unstable Medical Condition(s) [*List the recipient's current medical diagnoses and needs in relation to any unstable medical condition(s).*]

7. Seizures (*Note the frequency and severity within the past 3 months.*):

8. Mobility (*Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.*):

II. CURRENT SUPPORT SYSTEM

A. Primary Caregiver Information

Name: _____ Home Phone: _____

Does the primary caregiver live with the recipient? ☐ **Yes** ☐ **No**

If no, the caregiver's address: _____

_____

Does the caregiver work out of the home? ☐ **Yes** ☐ **No**

If yes, employer's name: _____ Employer's Phone #: _____

Work Hours: _____

Leave Home: _____ Returns Home: _____

B. List the Support System / Backup System for the primary caregiver when the Personal Care Aide is absent from the home. Include the name and times the support system is available to assist. *(The provider must be able to contact the recipient's support system in case of an emergency.)*

C. The amount of time in the Plan of Care for ADL care and Home Maintenance requirements: _____

D. The amount of additional support time required that can not be provided by recipient's support system.

# of Hours: _____ Between the time of: _____ and _____

_____

Agency / Screening Team

_____ _____

RN Supervisor/Service Facilitator or PAS Team Member Date

Instructions

If a recipient is requesting supervision, the provider must fill this form out completely and submit it to WVMI for authorization. WVMI must approve the request before DMAS will reimburse for this service.

REQUEST FOR PERS
(Personal Emergency Response System)

Recipients cannot have both PERS and Supervision time approved on the same Plan of Care.

Recipient Name: _____ Medicaid ID: _____

Primary Provider: _____ Provider Number: _____

PERS Provider: _____ Provider Number: _____

I. RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY PERS

A. **Cognitive Status:** Describe the recipient's cognitive status and impact it has on his/her behavior. If the recipient is confused at different times of the day, please explain. State whether the recipient can/cannot be left alone. If the recipient can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the recipient have appropriate judgement/decision making abilities? *(Be as detailed as possible. It is important that the RN make a correct appraisal of the cognitive status of the recipient. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.)*

B. **Physical Incapacity:** Describe the degree of physical incapacity and how it creates a need for PERS.

1. Incontinence:
   Bowel: _____ Frequency of Changes: _____
   Bladder: _____ Frequency of Changes: _____
2. Can the recipient change position/shift/transfer without assistance?
3. Skin Breakdown (*Note areas affected/recently documented problems within the last year, including dates*):
4. Potential for skin breakdown (*Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.*):
5. Falls [*Describe any falls that have occurred during the past 3 months, including dates and times of fall(s), and the scenario of the fall(s). Interactions and side effects of medications that may have contributed to the fall(s) must be included. Document what interventions, if any, have been put in place to prevent future falls.*]:

6. Unstable Medical Condition(s) [*List the recipient's current medical diagnoses and needs in relation to any unstable medical condition(s).*]

7. Seizures (*Note the frequency and severity within the past 3 months.*):

8. Mobility (*Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.*):

II. CURRENT SUPPORT SYSTEM

A. Primary Caregiver Information

Name: _____ Home Phone: _____

Does the primary caregiver live with the recipient? ❑ **Yes** ❑ **No**

If no, the caregiver's address: _____

_____

Does the caregiver work out of the home? ❑ **Yes** ❑ **No**

If yes, employer's name: _____ Employer's Phone #: _____

Work Hours: _____

Leave Home: _____ Returns Home: _____

B. List the Support System / Backup System for the primary caregiver. *(The recipient must have a support system if the PERS system becomes disabled. If the recipient is authorized for PERS, it is not necessary for a caregiver to live in the home with the recipient in the absence of a nursing aide. List the names of the persons who are a part of the support system. The provider agency must be able to contact the recipient's support system in case of an emergency.)*

C. The amount of additional support time required that cannot be provided by recipient's support system.
This time is important to ensure that the recipient will not be left with out an active and involved support system.
# of Hours: _____ Between the time of: _____ and _____

_____
Agency / Screening Team

_____ _____
RN Supervisor/Service Facilitator or PAS Team Member Date

Instructions

If a recipient is requesting PERS (Personal Emergency Response System), the provider must fill this form out completely and submit it to WVMI for authorization. WVMI must approve PERS with an authorization number before DMAS will reimburse for this service.

MI/MR LEVEL I SUPPLEMENT FOR EDCD WAIVER APPLICANTS

A. This section is to be completed by the Pre-admission Screening Committee.

Name: _____ Date of Birth: _____ Date PAS Request Received _____

Social Security No. _____ Medicaid No. _____ Responsible CSB _____

1. DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?

   ☐ Yes ☐ No (Check "Yes" only if both a and b below are answered "Yes".)

   a. Does the individual meet the program criteria for the Elderly or Disabled With Consumer-Direction Waiver AND is the individual at imminent risk? ☐ Yes ☐ No

   b. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs? ☐ Yes ☐ No

   (If "Yes", this form must be completed. If "No", do not complete Level I screening and do not refer for assessment of active tx needs. Individuals who do not meet the above criteria cannot be approved for Medicaid funded waiver services.)

2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? ☐ Yes ☐ No

   (Check "Yes" only if answers a, b, and c below are "Yes". If "No", do not refer for assessment of active tx needs for MI Diagnosis.)

   a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? ☐ Yes ☐ No

   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? ☐ Yes ☐ No

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ☐ Yes ☐ No

3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR) WHICH WAS MANIFESTED BEFORE AGE 18? ☐ Yes ☐ No

4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION? ☐ Yes ☐ No

   (Check "Yes" only if each item below is Checked "Yes". If "No", do not refer for Level II PAS for related condition.)

   a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment of services similar to those for these persons? ☐ Yes ☐ No

   b. Has the condition manifested before age 22? ☐ Yes ☐ No

   c. Is the condition likely to continue indefinitely? ☐ Yes ☐ No

   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? ☐ Yes (If yes, circle applicable areas) ☐ No

5. RECOMMENDATION (Either "a" or "b" must be checked.)

   a. ☐ Refer for Level II assessment for **:

      ☐ MI (# 2 above is checked "Yes")

      ☐ MR or Related Condition (# 3 or # 4 is checked "Yes")

      ☐ Dual diagnosis (MI and MR/Related Condition categories are checked)

** NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded waiver until the CSB has completed the DMAS-101B.

   b. ☐ No referral for active treatment needs assessment required because individual:

      ☐ Does not meet the applicable criteria for serious MI or MR or related condition

      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR

      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI

      ☐ Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stern level, or other conditions which result in a level of impairment so sever that the individual could not be expected to benefit from specialized services.)

      ☐ Is terminally ill (note: a physician must have documented that individual's life expectancy is six (6) months or less)

Signature & Title: _____ Screening Committee: _____

Date: _____ Telephone #: _____ Street Address: _____

INSTRUCTIONS FOR COMPLETION OF THE DMAS 101B
PROCESS FOR AUTHORIZING CBC SERVICES FOR PERSONS WITH MI/MR CONDITION

The pre-admission screening team must have this form completed when the person being screened has a condition of mental illness or mental retardation and the person is requesting community-based care services (Personal Care, Adult Day Health Care, Respite Care). Once the screening team determines that the person meets the criteria for CBC services (meets NF or Pre-NF criteria and is at risk of NF placement unless CBC services are offered) the screening team must complete the top portion of the DMAS 101, attach a copy of the UAI and send the two forms to the CSB for an evaluation of the person's need for MH/MR services. This must be done before the screening team completes the DMAS 96 to authorize services.

Any time the screening team has the CSB complete the MH/MR Service Needs Summary Form, *a copy must be attached* to the packet submitted to DMAS for reimbursement and a copy to the Elderly or Disabled With Consumer-Direction Waiver provider if services through this Waiver are authorized.

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC who Request services under the Elder or Disabled with Consumer-Direction Waivers

Attached is an assessment completed by _____ Preadmission Screening Team to determine the need and appropriateness of community-based services under the Elder or Disabled with Consumer-Direction (EDCD) Waiver (personal care, adult day health care, consumer-directed services, and /or respite care) for _____.
(Person Applying for Service)

As part of our assessment process, we have determined that the individual has:
____ *A condition of mental illness which requires assessment for services needed*
____ *A condition of mental retardation which requires assessment for services needed*

Please complete the information below and return it to _____ within 72 hours of
(Name of Screener Making Referral & Phone #)
the date referred _____ so that the assessment and authorization process can be completed.

TO BE COMPLETED BY THE COMMUNITY SERVICES BOARD (Attach additional information as needed.)

The _____ Community Services Board assessed the needs of the individual referenced above on
(Name of CSB)
_____ (*Date assessment completed).*

1. The individual does have a condition of mental illness or mental retardation and has the following active treatment needs:

   _____
   _____
   _____
   _____
   _____

   a. Active Treatment needs will be met by:

   _____
   _____
   _____

   b. If active treatment needs are met by a third party, please attach verification from the third party that all active treatment needs are being met. Also, if active treatment needs are being met by the school system, please explain how active treatment needs will be met during summer vacation:

   _____
   _____
   _____

2. The individual does have a condition of mental illness or mental retardation, but could not benefit from services. Please explain.
   (Note if this block is checked, but there is no explanation, services under the EDCD Waiver cannot be authorized.)

   _____
   _____
   _____

3. The individual does not have a condition of mental illness or mental retardation and therefore does not need treatment or services from the CSB.

Name of individual who completed assessment: (Please print name) _____

Signature of individual who completed assessment: _____

Phone Number: _____ Date Signed: _____

DMAS 101B revised 10/04

PATIENT INFORMATION

Medicaid ID:_____ **Provider Name:**_____
Recipient Name:_____ **SSN:**_____ **DOB:**_____
Address:_____

I. Provider Section

Payment Status (Complete Appropriate Blocks)
Report any admission, discharge, and/or change in patient status
Patient admitted to this facility/service on :_____(date)
Level of care: ☐ Skilled ☐ Intermediate
Patient discharged or expired on _____(date)
Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired
☐ Case in Need of Review/DMAS-122 requested
☐ Personal Funds Account balance $_____
☐ Patient's income or deductions have changed
☐ Other/explain:_____

Prepared by
Name:_____ Title:_____
Telephone:_____ Date:_____

II. DSS Section

Eligibility Information: (Check One)
☐ Is eligible for full Medicaid services beginning _____(date)
☐ Is ineligible for Medicaid services
☐ Is eligible for QMB Medicaid only
☐ Is ineligible for Medicaid payment of LTC services from _____ to _____ due to transfer of assets
☐ Is eligible for Medicare premium payment only
☐ Has Medicare Part A Insurance
☐ Has other health insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
	_____	_____	_____
Patient Pay Amount	_____	_____	_____

Comments:_____

Note: Medicaid Long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g. the SSA check received in January is used toward the cost of care in January.

Worker Name:_____

Agency Name:_____ FIPS Code:_____

Telephone:_____ Date:_____

PATIENT INFORMATION
FORM NUMBER DMAS-122

PURPOSE OF FORM—To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC waiver services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay of the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES—Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES—For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM—Complete the heading with the name of the nursing facility or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of all Medicaid services.
3. Check the third block if the individual is eligible as QMB only-(not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if the individual has other health insurance.

Patient Pay Information

Enter the month and year in which patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

RESPITE CARE NEEDS ASSESSMENT PLAN OF CARE

WAIVER (Check One): ☐ EDCD ☐ AIDS

A. RECIPIENT NAME: _____ Medicaid No: _____

B. PRIMARY CAREGIVER: _____ Relationship to Recipient: _____

C. STRESSORS: Describe factors that create a need for Respite Care.

Lack of Additional Support: _____

_____

Other Dependents: _____

24-Hour Supervision Required: _____

_____

Illness/Limitations: _____

Other: _____

_____

D. AMOUNT AND TYPE OF RESPITE CARE NEEDED

Reason Respite Care Requested: _____

_____

☐ Routine Hours/day: _____ Days Needed: _____

☐ Episodic Hours/day: _____ Specify Dates Needed: _____

Care must be provided by LPN: ☐ No ☐ Yes Describe Skilled Needed: _____

E. PATIENT PAY

Patient pay information obtained from: _____ _____
Eligibility Worker Phone Number

F. FREEDOM OF CHOICE

In accordance with the policies and procedures of the Department of Medical Assistance Services I have been informed by the Pre-Admission Screening Team of the Medicaid-funded, long term care options available to me by _____ and I choose:
Name of City/County or Hospital

☐ Respite Care Services ☐ Nursing Home Placement

I have been given a choice of the available Respite Care Provider agencies and my choice is _____I understand that only the amount of Respite Care authorized above can be offered. In order to receive Respite Care instead of nursing home care, I understand that the cost to Medicaid for Respite Care (and any additional Medicaid-funded Home and Community-Based Care services) must be equal to or less than the cost to Medicaid for nursing home care. The Pre-Admission Screening team has determined that the above Plan of Care is cost-effective, appropriate to meet my health arid safety needs and necessary to avoid nursing home care.

_____ _____

Physician's Signature & Date Recipient/Family's Signature & Date

ADULT DAY HEALTH CARE INTERDISCIPLINARY PLAN OF CARE

Recipient: _____ Medicaid #: _____

ADHC Name: _____ Provider #: _____

Start of Care Date: _____ Days & Hours of Attendance: _____

SERVICE PROVISION

1. **ADLs** – *(For Each Category Specify Type of Assistance and Frequency)*
   Toileting _____ Eating/Feeding: _____
   Transfer _____ Supervision: _____
   Ambulation _____ Bathing: _____

2. **NUTRITION**
   Meals/Snacks *(Specify frequency, type, special diet, allergy, etc.):* _____
   Nutritional Counseling: _____

3. **NURSING**

Medication	Frequency	Route	Medication	Frequency	Route

   Health Monitoring *(weight, vital signs, fluids, etc.):* _____
   Skilled Services: _____

4. **SOCIALIZATION / RECREATION**
   Counseling with recipient / family *(Specify subject, participants, etc.):* _____
   Recreational Restrictions: _____
   Socialization Needs: _____

5. **REHABILITATION**
   Therapies *(Specify type, frequency, & provider):* _____

6. **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**
   Is the recipient receiving supervision?: ___ Yes ___ No If yes, has he/she been informed of PERS?: ___ Yes ___ No
   Is the recipient receiving PERS?: ___ Yes ___ No **If the recipient has PERS, answer the following questions:**
   Is the recipient 14 years of age or older?: ___ Yes ___ No
   Is the recipient pleased with the service from PERS provider? ___ Yes ___ No

7. **CARE COORDINATOR / CASE MANAGEMENT**
   Recipient's primary caregiver: _____ Phone: _____
   Other non Waiver service providers: _____

Waiver services the recipient is receiving, and the provider agency at the time of assessment (check all that apply):

☐ Agency Personal Care: _____ ☐ CD Personal Care _____
☐ Agency Respite _____ ☐ CD Respite _____
☐ ADHC _____ ☐ PERS _____

What Waiver service is the patient pay to be deducted? _____

Staff Signature: Date:

Plan of Care Updating / Interdisciplinary Staff Meetings *(All staff initial their Entries)*

Date: _____ Evaluation/Comments: _____

Date: _____ Evaluation/Comments: _____

Date: _____ Evaluation/Comments: _____

Initial	Identifies	/ Initial	Identifies	/ Initial	Identifies

ADULT DAY HEALTH CARE DAILY LOG

Recipient's Name: _____ Medicaid ID: _____

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
DATE (Month/Day/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
ACTIVITY:							
Toileting							
Ambulation/Transfer							
Eating/Feeding							
Supervision							
Meals/Snacks							
Nutritional Counseling							
Administer Medication							
Health Monitoring							
Skilled Services							
Social/Rec. Activities							
Rehab. Support							
Transportation							
Other							
DAILY TIME IN							
DAILY TIME OUT							
NUMBER OF HOURS							

Weekly Comments & Date: _____

Weekly Signatures:

Recipient/Family's Signature Date ADHC Staff Signature Date

DMAS-302
rev.1004

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219

CONSUMER-DIRECTED RECIPIENT COMPREHENSIVE TRAINING FORM (OUTLINE & CHECKLIST)

(Check (√) the box after completing each part of the training.)

I. The Service Coordinator, the Personal Aide, and the Recipient

☐ A. Introduction to the Program

☐ 1. Structure of organization

☐ 2. Overall programs of the agency

☐ 3. Agency policies and procedures (e.g., payroll, record keeping, confidentiality, ethics)

☐ B. Consumer-Directed – Personal Attendant Services

☐ 1. Definition of services

☐ 2. The approach to provision of services

☐ a. Personnel involved (e.g., service facilitator, fiscal agent) (Have recipient read and sign service agreements for service facilitator and fiscal agent if they haven't been signed yet)

☐ 3. Role of the personal aide in the provision of services

II. The Recipient of Personal Aide Services

☐ A. Recipient needs inventory

☐ 1. Assessing needs as a recipient (e.g., habits, personal care)

☐ B. How to Select and Hire Personal Aides

☐ 1. Creating a personal aide job description (discuss sample)

☐ 2. Advertising for personal aides (discuss sample)

☐ 3. Assessing a personal aide's application

☐ 4. Required qualifications of personal aides

☐ 5. Screening applicants and scheduling interviews

☐ C. Hiring Personal Aides

☐ 1. Obtaining personal aide work record

☐ 2. Interviewing a prospective client (questions to think about)

☐ 3 Consumer selection of Personal Aide

☐ 4 Conducting a criminal history/references check

☐ 5. Record Keeping

III. Personal Care Aides

☐ A. Philosophy of personal aides

☐ 1. Policies for personal aides

☐ B. Payroll requirements for each personal aide

☐ 1 Employment eligibility verification (I-9)

☐ 2. W-4 Form completion

☐ C. Competency determination of personal aides

☐ 1 Competency certificate

IV. Contractual Agreements

☐ A. Agreement between consumer and personal aide

☐ 1. Sample personal aide agreement

☐ 2. Sample contract

V. Training Personal Aides

☐ A. The provision of services by the personal aide

☐ 1. Included services/excluded services

☐ 2. Sample personal aide duties check-list

☐ 3. Personal aide job evaluations

☐ B. Communicating with your personal aide

☐ 1. Creating a good work environment

☐ 2. Establishing rapport

☐ 3. Resolving conflict

☐ C. Important Considerations

☐ 1. Firing the personal aide

☐ 2. Emergency back-up personal aide

☐ 3. Substitution of aides

☐ 4. Accidents on the job

☐ 5. Unexpected death and the personal aide

VI. Completing Personal Aide Time Sheets

☐ A. Certification of services rendered (Explanation of time sheet)

☐ B. Understanding of relinquishment of patient co-pay amount

☐ C. Discontinued employment

This is to be filled out by the CD Service Facilitator during the Training and signatures obtained after the training.
This must be maintained in the recipient's file.

CD Recipient/Caregiver's Signature _____ Date _____

CD Service Facilitator's Signature _____ Date _____